

# NEXT ANNUAL SESSIONS

California Medical Association, Yosemite National Park, May 13-16, 1935  
American Medical Association, Atlantic City, New Jersey, June 10-14, 1935

# CALIFORNIA AND WESTERN MEDICINE

Owned and Published Monthly by the California Medical Association

FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

ACCREDITED REPRESENTATIVE OF THE CALIFORNIA AND NEVADA MEDICAL ASSOCIATIONS

VOLUME 42  
NUMBER 3

MARCH • 1935

50 CENTS A COPY  
\$5.00 A YEAR

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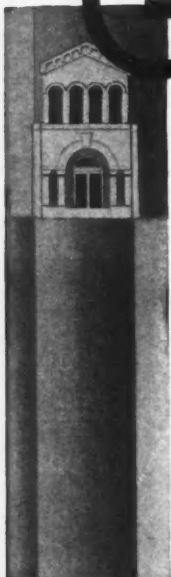
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VOL. 42

MARCH, 1935

No. 3

## THE TREATMENT OF CHRONIC ARTHRITIS BY DIET AND SUNLIGHT\*

By LOVELL LANGSTROTH, M. D.  
San Francisco

DISCUSSION by LeRoy H. Briggs, M. D., San Francisco;  
R. Manning Clarke, M. D., Los Angeles; W. D. Sansum,  
M. D., Santa Barbara.

THIS paper is based on a review of 100 cases of chronic arthritis seen in private practice. My aim in reading it is, first, to present the results of a study of these cases; second, to give the newer dietary methods that are used in the treatment of chronic arthritis; and third, to draw certain conclusions in regard to the nature and origin of chronic arthritis.

Because of the very brief time at my disposal, I intend to depart somewhat from the usual manner of presenting a medical paper, and omit practically all detailed discussion of the literature. It will be sufficient to state that the dietotherapy of arthritis is based on the work of Pemberton<sup>1</sup> and Fletcher.<sup>2</sup> It is necessary, however, to go briefly into the question of diagnosis, because each of the two main types of chronic arthritis, the degenerative, and the proliferative, of Nichols and Richardson,<sup>3</sup> require different methods of treatment. Each of these types also presents a distinctive pathologic picture.

### TYPES OF CHRONIC ARTHRITIS

In the *degenerative type*, there is a primary degeneration and then an erosion of the joint cartilage, with hypertrophy of cartilage and bone at the periphery of the joint, but no adhesions or ankylosis. This type is evidently not infectious. In the *proliferative type*, there is proliferation of the endothelial structures in the joint, pannus development over the articulating surface of the cartilage, and destruction of cartilage by granulation tissue from both the joint side and the epiphyseal side. Adhesions and ankylosis do occur.

The proliferative type seems to have the nature of an infectious disease, though there is a great deal of doubt as to whether the attenuated streptococcus, said by Cecil<sup>4</sup> to be found in the blood stream and joint tissues, is really the primary cause of the disease.

Degenerative arthritis is much more frequent than proliferative arthritis. In the 100 cases which were studied as a basis for this paper, there were seventy-seven cases of degenerative arthritis and only eight cases of proliferative arthritis, a ratio of nine to one. The average age of onset in these seventy-seven cases was forty-four, which makes this disease one of middle life. When grouped according to constitutional type, i. e., as to whether they were broad, average or slight, the average was found not to differ from that of a group of 100 controls. This form of the disease was found to involve the spine in fifty cases, the knees in twenty cases, the fingers in nineteen cases, and the shoulders in seventeen cases. While males and females were about equally affected in the spine, females had more frequent involvement of the knees and fingers, and males of the shoulders. But as the duration of the disease in years increased, there was a tendency for more than one joint to be involved, and finally for all the joints to be involved. The symptoms generally appear insidiously with stiffness and "cracking" in the joint after inactivity, as in the knees after sitting; but pain on movement soon follows, and then increasing disability. In the fingers, hypertrophy of bone at the periphery of the joint is quite evident on inspection, and similar hypertrophy is shown by roentgen rays in other joints, although, in my opinion, roentgen-ray evidence is not necessary to establish a diagnosis.

In proliferative arthritis, the average age of onset was thirty-two, and this was also the age of onset of a group of miscellaneous diseases in the group of controls, so this form of arthritis appears at a much younger age. And while in degenerative arthritis the patient will often say that, apart from his affected joints, he is perfectly well, this is rarely the case in proliferative arthritis, where he will often complain of fatigue, loss of strength, and a general sense of not being well. The soft parts about an affected joint seem thickened, the capsule usually contains fluid, the joint has a typical fusiform shape, motion is limited and painful, there is marked tenderness on pressure, and muscular atrophy may be marked. The affected joint may clear up for a time, only to reappear in a year or more; and if the disease is not arrested there is a marked tendency for all the joints to be involved, and finally for the patient to become utterly helpless in bed.

\* Read before the General Medicine Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

## BORDER LINE TYPES

While it is easy to differentiate these two types of arthritis, there are many cases which it is difficult to classify properly. These cases seem to be intermediate between the extremes of degenerative arthritis on the one hand, and proliferative arthritis on the other. It thus seems possible for the degenerative type to be complicated by what may be called the infectious element, as it was in eight of my cases; or for milder degrees of "infectious arthritis" to remain localized to one joint, or to clear up without going on to the typical picture of proliferative arthritis, as in four of my cases. This form of infectious arthritis is often limited to one or two joints, though it may wander from one to another and involve so many that it is difficult to distinguish it from atypical forms of rheumatic fever. The more acute forms tend to recover spontaneously with rest and simple measures. The subacute forms not infrequently clear up when diseased tonsils or abscessed teeth are removed, and are probably responsible for the hypothesis that infectious arthritis is always due to focal infection.

## RESPONSE TO DIETOTHERAPY

Degenerative arthritis is usually favorably affected, or completely relieved, by proper dietotherapy, though some cases seem to resist treatment. Thus in seventy-two cases treated by diet, five were not improved, thirteen were slightly improved, thirty-nine were much improved, and fifteen were completely relieved. Curiously enough, the chances of relieving the patient seem to vary directly with the inadequacy of his previous diet. It has been my custom for some years to take and record a dietary history on each patient, and while these histories show that the average diet of the seventy-seven patients with degenerative arthritis does not differ from the average diet of the 100 control cases in respect of the percentage of protective foods, they do show that when a diet high in protective foods is instituted, relief will be most striking in those cases where the inadequacy has been greatest, and particularly when the amount of bread eaten has been greatest. If we divide my seventy-two treated cases into two groups on the basis of their improvement, following a diet of protective foods, we find eighteen cases not improved or slightly improved, and fifty-four cases much improved or completely relieved. If we then compare the dietary histories of the first group with those of the second, we find that the diet of the second group (that made the greatest improvement), contained 30 per cent more bread than that of the former group (which made the least improvement). Perhaps it is not fair to single out bread in this way as having an unfavorable effect on degenerative arthritis, but it is the food which is generally substituted for the protective foods, and its presence in unusual amounts is thus an indication of a gross deficiency in respect of these protective foods. At any rate, it was the food which stood out most prominently in these dietary histories as having a relation to improvement when a proper diet was instituted.

TABLE 1.—*Depletion Diet*

<i>Breakfast</i>
Glass of orange juice
Fresh raw fruit
Black coffee
<i>Luncheon</i>
Glass of orange juice
One-third head of lettuce with French dressing
and tomatoes or any raw fruit or vegetable
Two fresh cooked vegetables
Fresh raw fruit
<i>Dinner</i>
Same as luncheon

## DEPLETION DIET

The average patient with degenerative arthritis is ambulatory, but occasionally a severe attack of pain in sacro-iliac arthritis, or fluid in the knee joint, will necessitate his being put to bed for a time. His general health is usually fairly good, and it is not necessary to insist on as much rest as in proliferative arthritis. The diet given depends on his weight, age, activity, and appetite. Middle-aged, inactive and overweight patients are given what I call a depletion diet, provided I can be sure of seeing them several times a week for the first few weeks of treatment. This diet is given in Table 1.

This depletion diet is bulky and very high in protective foods, but contains very little protein and fat, and no concentrated food except the salad dressing. I instruct the patient not to continue it longer than three days without consulting me. Not infrequently he returns after this interval with some evidence of improvement, but he may complain of weakness, dizziness, and sweating, which, in my experience, are associated with the change in the character of his food, and not with the lowered caloric intake. I like to wait until he insists that he is very hungry, and then I increase his diet by adding small amounts of food at two or three-day intervals until I have added two or three glasses of milk, two eggs and a serving of meat, fish or chicken, the object being to prolong the period of depletion and to slowly institute the full basic diet of protective foods. During this period of depletion there is often a loss of eight or ten pounds weight, and usually a marked improvement, with gradually increasing freedom from pain, stiffness and disability. The patient feels better generally, and looks better, too, particularly as to quality and color of skin, and brightness of sclerae.

## DIET OF PROTECTIVE FOODS

When the patient has only a small amount of pain and disability, or is forced to continue actively in his occupation, the basic diet of protective foods is prescribed at once. This diet is given in Table 2.

It is usually possible to maintain a satisfactory weight and to satisfy the appetite on this diet, as the patients are in middle life, and not doing physical labor. If it proves inadequate, Ry-krisps, potato, or whole wheat bread can be added in small amounts, though I prefer to make additions of milk or fruit, if nourishment can be maintained on them.

TABLE 2.—Basic Diet of Protective Foods

<i>Breakfast</i>	
	Glass of orange juice
	Two eggs
Fresh fruit, preferably raw, but cooked occasionally,	with a minimum of sugar and no cream
Glass of milk, heated and taken with coffee if desired	but without added cream or sugar
<i>Luncheon</i>	
One-third head of lettuce with French dressing and	added tomato or any raw fruit or vegetable
	Two fresh cooked vegetables
	Glass or two of milk
	Fresh fruit
	Glass of orange juice
<i>Dinner</i>	
	Meat, fish or chicken
One-third head of lettuce with additions as above	
	Two fresh cooked vegetables
	Glass of orange juice
	Fresh fruit
Cheese, fresh nuts, raisins, dried figs, or dates	
No soup, cereal, starch, paste, sugar, cream or butter	
(except in cooking). No bread, potato, or canned food.	

## PHYSIOTHERAPY AIDS

Physical therapy is a helpful adjunct to dietotherapy at times. Actinotherapy has a good general tonic effect on the tissues; heat and diathermy are useful in spinal arthritis with referred pain down the arm (the so-called neuritis), and massage of the back muscles is helpful occasionally in spinal arthritis. Postural exercises are particularly important in sacro-iliac disease and arthritis of the spine, but should generally be used after the pain has been controlled by diet.

## TREATMENT IN PROLIFERATIVE ARTHRITIS

The approach to proliferative arthritis is quite different. When the disease is well advanced, the patient is often underweight and fatigued, and looks ill. He will not make progress under any régime unless he can be put at rest, but this does not mean that he must be in bed. Since his treatment must be continued for several years, the wisest practical course is to allow him what small amount of activity he is able to take, and let him be up and around his room, house, and yard. Immobilization of the joints seems indicated on theoretical grounds, but is often impossible because so many joints are involved. The full basic diet of protective foods, or as much of it as can be taken, is given at once. Heliotherapy is almost indispensable in proliferative arthritis, and artificial sunlight is a poor substitute. The patients who have done best are those who have moved into regions where sunbathing is possible for eight months of the year. After the patient is thus established, and treatment begun, there is an interval of several months before improvement begins; and during this period every effort must be made to support his morale. When improvement does begin, it first becomes evident in a general way: the patient feels and looks less fatigued, has a better color, and better digestive function. This is followed by a decrease of swelling and pain in some of his joints, and from this point on progress is slow but fairly steady, though there may be discouraging periods of fever and relapse. When all signs of activity have disappeared in the joints, then massage, passive, and active movements are begun, and continued so

long as there is hope of increasing the range of motion. Motion in some of the joints may be impaired or lost because of ankylosis and subluxation; but, in spite of these permanent disabilities, the patient is no longer a hopeless invalid, and is often able to lead a life of moderate activity.

## TREATMENT OF INTERMEDIATE TYPES

The type of arthritis which I have classified as intermediate between degenerative and proliferative is often restricted to one or two joints such as the shoulder or knees, and these joints then contain fluid and are sometimes quite painful. If the case is seen from the beginning, it is best to immobilize these joints in some form of splint for a few days till the pain is relieved, and then gradually remove the support for institution of massage, passive motion, and diathermy. When this sort of immobilization is added to the dietotherapy and actinotherapy, such a joint will often be restored to full function in a few weeks.

While improvement has been marked in both types of arthritis under the treatment outlined, it is a striking fact that any considerable relaxation of vigilance as to diet in the degenerative group, or rest and sunlight in the proliferative group, will soon bring on symptoms. In other words, we have succeeded in arresting the progress of the disease, or in restoring painless function, but we cannot be said to have cured it in any sense, for the old environmental conditions will allow it to progress again.

## RÔLE OF FOCAL INFECTION

Focal infection has commonly been held responsible for all types of arthritis, the theory being that abscessed teeth or diseased tonsils served as a portal of entry for the streptococcus, which secondarily infected the joints. I found a history of such focal infection to be more frequent in my seventy-seven cases of degenerative arthritis, and much more frequent in my twenty-one cases of infectious arthritis, than in the control group. I believe these figures indicate that patients with proliferative arthritis, at least, are more susceptible to focal infection. When this susceptibility is considered in relation to the occasional miraculous cure of an arthritis of the intermediate type by extraction of an abscessed tooth, and to the fact that the activity in proliferative arthritis is slowly overcome by measures calculated to raise the patient's resistance, it strongly supports the notion that the disease is infectious, and that the attenuated streptococcus is its cause. On the other hand, the removal of foci was not beneficial in my eight active cases, for six had had their tonsils cleanly removed, and all had had their abscessed teeth removed, and there seems to be a clear relation between recovery and protective foods and sunshine, so that it is quite possible that we are dealing with a deficiency tissue disease related to vitamin D, and that the attenuated streptococcus is merely a secondary invader. But even if this streptococcus is eventually found to cause the lesions, I believe that it is only able to gain a foothold in these persons because of a primary lack of resistance. This attitude toward focal infection seems to me extremely important because of its

therapeutic implications. If the patient's lowered resistance is primary, and the invasion by the streptococcus secondary, then our main therapeutic efforts should be directed toward raising his resistance, and removal of diseased tonsils and dead teeth should play a secondary rôle.

#### INFLUENCE OF ENVIRONMENTAL FACTORS

Thus far, the evidence presented tends to show that both forms of chronic arthritis are influenced favorably by environmental factors, and that food constitutes the important environmental element in degenerative arthritis, and rest and sunlight in proliferative arthritis. I should be happy to say that the histories of these patients showed that their diet or their sun exposure had been below the average, but this is not the case. The patient with degenerative arthritis takes about the average diet in regard to protective foods, and the patient with proliferative arthritis has not had less sun exposure than the 100 controls. In other words, we face the paradox that environmental factors can be shown to overcome both forms of chronic arthritis, but cannot be shown to have anything to do with their origin. Our dilemma is made worse by the fact that the disease is held in abeyance only so long as the improved environmental conditions are maintained. I have tried to answer this riddle by assuming that these patients developed chronic arthritis because of a tendency inherent at birth—a tendency to degeneration on the one hand, and to infection by whatever attenuated organism may eventually be proved responsible on the other. Degenerative arthritis would thus be explained by the occurrence in certain persons of an inherent tendency to degeneration of joint cartilage under ordinary dietary environment, but this tendency would be held in abeyance by special dietary environment. Proliferative arthritis would be explained by the occurrence in other persons of an inherent susceptibility to infection of the joints with some attenuated organism; but this susceptibility, too, would be held in abeyance by special environment as regards foods, rest and sunlight.

#### IN CONCLUSION

Degenerative arthritis is probably due to an inherent tendency of the joint cartilage to degeneration, and this degenerative process is modified by the food intake. A diet high in protective foods usually gives relief from symptoms.

Proliferative arthritis is probably due to an inherent tendency to infection of the joints by some attenuated organism. This infection may be overcome by prolonged sun treatment and a diet high in protective foods.

516 Sutter Street.

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#### DISCUSSION

LEROY H. BRIGGS, M. D. (384 Post Street, San Francisco).—The question of the efficacy of any treatment in such a chronic disease as arthritis is surrounded by so many variables that conclusions, other than that by the infallible test of time, are well nigh impossible. Two of the most characteristic features of the degenerative type are the fluctuations of the symptoms and the permanence of the bony changes, the former being based largely on subjective evidence, the latter on objective. True, in the soft-tissue variations of an acute exacerbation and decrement, we have objective evidence of change; but these may occur spontaneously and apart from any treatment. One starts, therefore, with the premise that evidence of improvement dependent on a given therapy is mainly subjective, and more or less of an uncertain quantity. Furthermore, the hope engendered in the mind of the patient by a new and definite mode of treatment, enthusiastically supervised, is certain to achieve psychic improvement, even though temporary.

There is no question that the reduction in surplus weight of the soft obese arthritic patient is a betterment, relieving the joints, especially the larger weight-bearing ones, of two of the most pernicious factors of the disease, strain and fatigue. This is of definite benefit, provided it is not carried too far; but one feels that it is immaterial as to how this caloric lowering is done, for it would seem that the improvement results from the actual loss of weight rather than from the removal of any suppositively deleterious elements in the diet. It is as yet far from proven that intestinal fermentation and putrefaction are etiologic elements; and as for a high vitamin diet, the adult on an ordinary ration certainly gets an adequate quota for his needs.

In the proliferative type, a low diet may possibly be a detriment rather than a benefit. These people usually are undernourished and depleted, partly from the nature of the disease as well as all too often from various dietary procedures previously attempted in the hope of cure. Personal experience appears to point that feeding them to bring about a better state of nutrition is more productive of good than harm, as in the case of any chronic infectious process.

As far as actinotherapy in arthritis is concerned, no clinical proof yet has been offered that any benefits result other than those derived from a changing circulation. In a degenerative process, and to some extent in a chronic low-grade infectious one, an increased vascularity of even the tissues peripheral to a joint might be of use. The immense present popular appeal of the method, together with the visual evidence of a change in color, might in many instances bolster up the general morale of a patient, depressed by the contemplation of a chronic process undergoing a therapeutic standstill.

It must be admitted that a certain tinge of pessimism has been induced in the mind of one who has seen these patients over a period of years, not with the eye of the specialist temporarily scrutinizing damaged joints, or surveying varying foci of infection, but from the broader horizon of the practitioner of medicine, noting what mediocre success greets the numberless therapeutic trials over the span of time. However, any measure that inspires hope and builds up morale, even for a short time, is well worthy of use, provided it does no harm. Faith sometimes may accomplish the seemingly miraculous.

✱

R. MANNING CLARKE, M. D. (1219 Hollingsworth Building, Los Angeles).—This paper is certainly timely, since, like the poor, we have these arthritics always with us. I am grateful to the Doctor for bringing once more forcibly to our minds the things that can be done to help these sufferers. The work of Pemberton most of all, but also of Richardson, Cecil, Fletcher and others have been well received. Doctor Langstroth has set us an excellent example in his ability to use this knowledge for the relief of his patients; and what is more important, how to use

it as a vehicle of study, and a road to more knowledge. We all look forward to the day when the etiology of arthritis will be more definitely understood. In the light of that day we will, of course, have better and more intelligent treatment.

One of the interesting things brought to view in these studies of arthritis was that the sugar tolerance showed a tendency to be lowered. Fletcher found that "a large majority of his cases studied showed a lowered sugar tolerance." He found that women showed a greater improvement and response to diet reduction than did men, and also that they usually showed a lower sugar tolerance. Doctor Langstroth has no doubt noted this improvement in sugar tolerance, while his cases were on the depletion diet he has shown us, especially if they were female and obese.

I desire to especially note in passing that I like the attitude presented in the paper as regards the subject of focal infection. I think it expresses well balanced, good judgment.

W. D. SANBURN, M. D. (Santa Barbara Cottage Hospital, Santa Barbara).—The noninfectious, degenerative type of arthritis is a disease of unknown cause for which the treatment has been unsatisfactory. Doctor Langstroth's work seems to show that diets high in protective foods, together with sunshine, are valuable adjuncts in the treatment of this condition, and also in the treatment of the infectious, proliferative types. Inadequate diets might be one of the causes of the degenerative type, and they might lower one's resistance to infection.

Allergic arthritis is probably more common than we formerly supposed. It may be that the depletion diets used in the beginning help an allergic factor, if present.

DOCTOR LANGSTROTH (Closing).—In the investigation of any clinical problem there are two forces at work—a positive constructive or creative force, which aims to modify a disease process, or to better the actual conditions, and a negative, destructive or denying force, which aims to maintain the *status quo*. One tends to interpret the phenomenon in the light of its own creative will, and may therefore distort the facts and see only what it desires to see; the other tends to interpret the phenomenon in the light of its negative will, and may therefore fail to see what it desires not to see. The latter force is only healthy in so far as it keeps the former from going off into unreality. In this investigation I have tried to maintain a proper balance between these two forces. I do not claim to have found methods of treatment that are universally or completely successful, but to have merely pointed out certain conditions which modify the disease process in arthritis. The work itself is an attempt to apply the newer knowledge of nutrition to a phase of clinical medicine where therapy heretofore has been quite sterile. The diets used are based entirely on the work of such men as McCollom and McCarrison, and therefore have a good scientific background. Those of my associates who have seen this work in the clinic are convinced that the results are not overstated.

Much of the criticism directed against the advances in our knowledge and application of the principles of good nutrition is more revealing of a general attitude than convincing as argument. A large part of such criticism comes from individuals who are uninterested in nutrition, and have never made a careful trial of the methods they criticize. It cannot be refuted in detail because it merely denies; it is an attempt to rationalize the negative will to maintain the *status quo*. It is as much as to say: I do not think these results can be possible; therefore the results are not factual.

It is interesting to consider for a moment the psychological motivation of this negativistic attitude. Maintenance of the admittedly unsatisfactory *status quo* is evidence of fear of change, and this fear of change in turn is evidence of a narcissistic fear of making a mistake. In other words: rather than run the risk of making a mistake I will remain static; that is much safer.

## LYMPHOGRANULOMA INGUINALE\*

REPORT OF A CASE ORIGINATING IN  
NORTHERN CALIFORNIA

By FREDERICK G. NOVY, JR., M. D.  
Oakland

DISCUSSION by Eugene F. Hoffman, M. D., Los Angeles;  
Samuel Ayres, Jr., M. D., Los Angeles; Anthony B. Diepenbrock, M. D., San Francisco.

LYMPHOGRANULOMA INGUINALE (Lymphopha-thia venerea) was first described as a separate clinical entity in 1913 by Durand, Nicolas, and Favre<sup>1</sup> of France. This condition had previously been observed and reported under various names, as climatic bubo, strumous bubo, tropical bubo, non-venereal bubo, and non-tuberculous lymphadenitis. Apparently the first report was in 1859 by Chassaignac,<sup>2</sup> who cited cases of peculiar inguinal lymphatic masses. From that time on, various reports were made of this condition, coming mostly from tropical countries.

After the first report by Durand, Nicolas, and Favre, little interest was taken in the condition until after the World War. In 1922 they again brought the disease to the attention of the profession in a long and exhaustive study.<sup>3</sup>

Many articles have been written on the subject since this time, and several other names for the malady have been suggested, such as the "fourth venereal disease." This, however, immediately conflicts with some of the English writers, who feel that granuloma inguinale should be the fourth disease, Vincent's infection of the genitals, the fifth disease, and that lymphogranuloma inguinale should be called the sixth. Wolf and Sulzberger<sup>4</sup> suggested the term "lymphopha-thia venerea," which is by far the best, in that it is not confusing with granuloma inguinale and implies its venereal nature and involvement of the lymphatic structures. However, the term is open to some criticism in the use of the word "venerea."

The rapid spread of the recognition of this condition was augmented by the discovery, in 1925, of a specific test for the disease by Frei. In the next three or four years after the announcement of this test nearly every country had reported some cases, and its almost universal incidence was recognized. Recently several extensive articles on this disease have appeared in this country, and for a complete review of the literature the reader is referred to such comprehensive articles as those of De Wolf and Van Cleve,<sup>5</sup> Zakon,<sup>6</sup> and Cole.<sup>7</sup>

### DISTRIBUTION IN THE UNITED STATES

For many years naval and public health officers have reported in ports of this country cases of climatic or tropical bubo. Most of these patients gave a history of having been in the tropics, and they were thought not to have received their infection endemically. These cases were probably in many instances lymphogranuloma inguinale.

\*From the Division of Dermatology, Department of Medicine of the University of California Medical School, San Francisco.

Read before the Dermatology and Syphilology Section of the California Medical Association, at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

In 1924, at Boston, Hansmann,<sup>8</sup> under the title of "non-tuberculous granulomatous lymphadenitis," published a series of cases which probably were examples of this condition. In 1927 Barber and Coogle,<sup>9</sup> using the same term, reported cases from Mississippi.

The first case reported using the term "lymphogranuloma inguinale" was that reported by Hillman, Wilshusen, and Zimmerman<sup>10</sup> in September, 1928, from New Haven, Connecticut. In December, 1929, Gross<sup>11</sup> presented a case at the New York Academy of Medicine, and since then at the different medical meetings in that city many new cases have been shown. For several years it was felt that this disease was confined to coast cities, being brought into this country by sailors from abroad. However, this view rapidly changed when De Wolf and Van Cleve<sup>5</sup> in 1932 reported a remarkable group of fifty-eight cases from Cleveland. Subsequent reports bring the total to nearly one hundred cases seen in that city, many of them endemic and of years' duration. In the same year Amtman and Pilot<sup>12</sup> reported three cases from Chicago, two of which were acquired locally. Tomlinson and Cameron<sup>8</sup> had three cases in Omaha in 1933. One of these apparently contracted his infection in Kansas City.

In the South, so-called "climatic bubo" has been long recognized, and in the past year Brown<sup>14</sup> has noted several cases in dispensary practice in Jacksonville, Florida. They were definitely lymphogranuloma inguinale, and he states<sup>15</sup> that he feels it is more common than chancroidal infection in that locality. De Wolf<sup>18</sup> has recently seen one case in Little Rock and another in Hot Springs, Arkansas.

Here in California, Hoffman<sup>17</sup> reported eleven cases from Los Angeles in November, 1933. Eight of these contracted their infection in Los Angeles County.

It appears from the above that this disease is widespread throughout the country, and is not limited to coastal areas. In all probability, it has been present for a long time, unrecognized as a separate disease, and called either chancroidal or gonorrheal bubo.

Now that so many reports have been made, new cases undoubtedly will be appearing in the other sections of the country.

#### CLINICAL DESCRIPTION

Lymphogranuloma inguinale starts with a primary lesion which appears a few days post coitus. This lesion is ordinarily transitory and benign in character, so that the patient frequently is not aware of its existence. This is particularly true in women in whom it is usually on or near the cervix or folds of the labia. Four types of primary lesions have been noted: (1) herpetic, (2) ulcerative, (3) nodular, (4) nonspecific urethritis, with scanty thin discharge which is negative for organisms. The first of these is by far the most frequent and remains only a few days, resembling a herpes praeputialis.

After a second incubation period of between ten days to three weeks, the patient begins to notice a swelling in one or both groins. This is

often associated with general malaise and fever, which is usually from 39 to 40 degrees centigrade (102.2 to 104 degrees Fahrenheit) and may last for several weeks. Other constitutional symptoms, which may accompany the enlargement of lymph nodes, are gastro-intestinal upsets, pains in the joints and muscles, headaches, toxic manifestations on the skin as erythema multiforme and erythema nodosum.

The glands are usually unilateral, but may be bilateral if the primary lesion is near the mid-line. At first they are hard and tender, but not particularly painful. As they increase in size they fuse to form a large mass. The overlying skin becomes tense, shiny, and later takes on a reddish violet color. Not infrequently the skin becomes attached to the inguinal mass. Areas of softening then occur in the glands, which break down, developing numerous fistulous openings from which drain a thick purulent pus. As new areas become involved this cycle continues with softening and sinus formation. In more severe cases this may spread to involve the deeper lymph glands of the pelvis and about the rectum; here they do not usually break down, but as the infection subsides become fibrotic. Ordinarily, after draining for some months the sinuses close and heal spontaneously, but occasionally they may remain open and drain for years.

In females the clinical picture is quite different in that the primary lesion is on the cervix or posterior fornix, so that the deep pelvic nodes are almost immediately involved, giving rise to vague lower abdominal symptoms. If, however, the site of invasion is about the external genitalia, the superficial inguinal nodes will be involved. The end-result of this involvement is blockage of lymph drainage of the vulva and the resultant elephantiasis of the labia which may break down, forming fistulous tracts and ulcers. This condition has been described as esthiomene and has long been known under this name.

The most serious complication of this disease is the involvement of the pelvic lymph-nodes, resulting in fibrosis of the nodes and finally rectal stricture. This is naturally more common in females because of the lymph drainage.

Years ago Fournier described a syndrome of multiple sinuses draining into the rectum or perineum. Associated with this was an infiltration of the rectal wall with stricture formation. He believed that the syndrome was on a syphilitic basis, and it has been known as the anorectal syphiloma of Fournier. However, this condition has never responded to specific therapy. Since the introduction of the Frei test many of the cases that were previously thought to be syphilitic have been shown to be cases of lymphogranuloma inguinale. Martin<sup>18</sup> recently reported a series of twenty-five cases of stricture of the rectum, of which twenty showed positive Frei tests. Streicker, in the discussion of this paper, had a series of nineteen cases, all with positive Frei tests.

#### ETIOLOGY

From the nature and course of the disease it has long been thought to be of venereal character,

and many cases have been cited of transmission by sexual intercourse. Extragenital infections are rare. Two cases involving the finger have been observed, one by Hellerström and the other by Ravaut, both of these being in physicians. Curth<sup>19</sup> and Bloom<sup>20</sup> have recently reported a case of primary involvement of the tongue with cervical adenitis. Other extra-genital cases have been observed.

This disease has been shown to be due to a filterable virus by Hellerström and Levaditi, Marie and Lepine.<sup>21</sup> They have inoculated apes subdurally and have been able to carry the virus through a series of animals and then reproduce the disease in humans by means of preputial inoculations. Filtrates from the emulsion of brain and spinal cord of inoculated animals have given a specific intradermal reaction similar to the Frei test. The picture seen in monkeys is that of a fatal meningo-encephalitis. Successful inoculations to rabbits, guinea-pigs, and mice have been reported in some instances.

The virus is resistant to cold, but is easily destroyed by heat and loses its virulence in glycerin. Coutts<sup>22</sup> believes that there are two definite types of this virus; one type of genital and the other of buccal origin. This latter type manifests itself with more general symptoms, and there are also two types of antigen, so that one type will not react in a case in which the other type of virus is responsible for the disease. This concept of two distinct viruses will have to be substantiated by further experimental and clinical observation.

#### PATHOLOGY

Grossly the glands present a mass bound together by thick perinodal exudation often attached to the skin. On sectioning, multiple small abscesses are seen which contain thick creamy pus.

Histologically, the lymph-nodes present a definite granuloma replacing the normal lymph-node structure in which are found numerous microscopic abscesses often stellate in shape, and filled with lymphocytes and cellular debris. These abscesses are walled off by epithelioid cells which are often in palisade arrangement. Plasma cells and leukocytes are seen and occasionally giant cells of the Langerhans type. This picture is thought by some authors to be specific for the disease.

#### THE FREI TEST

This test has been found to be specific by most workers. The antigen is prepared by diluting the pus from a bubo of a known case obtained under aseptic conditions, with physiologic saline solution. The dilution is 1:5 or 1:10, depending on the thickness of the pus. It is then sterilized at 60 degrees centigrade in a water bath for two hours on the first day, and one hour on the next day. The solution is tested for sterility and checked on a known positive case. An intradermal injection of 0.1 cubic centimeter of this solution is made and the reaction is read in forty-eight to seventy-two hours. A positive reaction is one which presents an infiltrated papule at least 0.5 centimeter in diameter. Around this there may be a wide

erythematous halo. Occasionally the reaction is so severe as to cause local necrosis. The test probably always remains positive many years after the time of infection.

#### DIAGNOSIS

In all cases of regional lymph-gland swelling, this condition should be kept in mind, and particularly is this true of the inguinal glands. If there is a history of a fleeting genital lesion the chances of dealing with this condition are more than suggestive. A positive diagnosis can be made by the use of the Frei test.

Granuloma inguinale simulates lymphogranuloma inguinale only in name and location, as it is primarily a disease of the skin presenting itself as a superficial, slowly advancing, undermining ulcer which may spread over the entire lower abdomen, but which never involves the lymph-nodes nor invades the deeper structures. Smears from these cases show the Donovan bodies in mononuclear cells, and the Frei test is negative.

In chancroidal infection the adenitis is more painful and acute, and breaks down with one central necrotic area. At the time of the adenitis there are usually several chancroidal ulcers present on the skin in which the bacillus of Ducrey can be found and the Ito-Reënstierna reaction will be positive. This latter is a reaction similar to the tuberculin test. The antigen is made from Ducrey organisms. Auto-inoculations are positive in cases of chancroidal infection and not in lymphogranuloma inguinale.

The adenitis due to syphilis is very different in that the glands are firm, painless, discreet, and do not break down. Darkfield examination and serologic tests also serve to confirm the diagnosis.

Other conditions to be considered are: Hodgkin's disease, lymphosarcoma, pyogenic infection, tularemia, bubonic plague and metastatic glands from a neoplasm.

#### TREATMENT

Many types of therapy have been advocated for this condition. Most of the intravenous medications have been used with indifferent results. Tartar emetic has probably been the most satisfactory. X-ray therapy has been of little value, and in some instances has aggravated the condition. Incision and drainage in the less advanced cases have proved to be of value. Total extirpation of the glands has the disadvantage in that occasionally an elephantiasis develops in the dependent part due to loss of lymph drainage. Kalz<sup>23</sup> reports good results from the use of convalescent serum. Recently Wien and Perlstein<sup>24</sup> made a preliminary report in which they state that they have had consistently good results with the intradermal injections of Frei antigen. Their method of procedure has been to give 0.1 cubic centimeter intradermally, at three- to five-day intervals. Improvement has been noted after only a few injections. In one case, Thomas and McCarthy,<sup>25</sup> with the use of Besredka type of bouillon filtrate, observed definite and rapid response.

The treatment of rectal stricture due to this disease has been most unsatisfactory until the

introduction of the intradermal injections of Frei antigen. Since then some of these cases have been definitely improved with this type of therapy.

#### REPORT OF CASE

**F. A.**, age forty-four years, Mexican, living for the past eighteen years in California, entered the surgical department of the University of California Clinic on October 26, 1933, complaining of a swelling in the right groin.

**Past History.**—The patient has had a Neisserian infection twice. The last infection was several years ago. He has had no symptoms from this for some time. There was no history of syphilis. He has not had any other serious illness, and the past history is otherwise negative.

**Family and Marital History.**—Of no importance.

**Present Illness.**—In May, 1933, the patient went North with the Alaskan fisheries, working there until the latter part of July, returning to San Francisco August 12. He denied having had sexual intercourse during this time. Immediately on his return to San Francisco, he had numerous exposures with several women. A week later he noticed a small penile lesion which he described as a "hair cut." This he treated a few days with mercurochrome, and it cleared up promptly. About ten days later he began to notice a swelling in the right groin which gradually increased in size and continued to do so until it broke down with the discharge of pus. There was some pain associated with this, which has been of a dull, aching character, and also some pain radiating down the leg.

For some time, he has had constitutional symptoms of loss of weight, general malaise, and fever. The latter was more noticeable at night and sometimes associated with sweats. The joints of the legs have been painful at irregular intervals. There has been no nausea or headaches.

**Examination on Entrance.**—The patient presented a large, hard, non-fluctuant mass in the right inguinal region. The overlying skin showed a bluish discoloration and was tense. There were two sinuses present, about two inches apart, along the line of the inguinal ligament. The penis showed no active lesion, but a small soft scar below the corona in the mid-line was present. The right leg presented no pathology on examination. Impression at this time was right inguinal bubo, origin and etiology unknown.

**Subsequent Course.**—On October 30, 1933, the right inguinal region was opened under general anesthesia, with a wide incision, and drained. Following this there was an increased swelling in the area which gradually subsided. Pus continued to drain freely particularly upon pressure. This was seropurulent in type for the most part, but sometimes was thick and creamy. The bubo was treated with injections of saline and packed with balsam of Peru. After the incision there was very little pain at any time.

Examinations of pus for organisms were negative and a guinea-pig inoculated at this time later showed no evidence of tuberculosis. Urine examination was negative. The blood showed a leukocytosis of 19,000, and the differential was normal. The serology was positive both to the Wassermann and Kahn reactions, but examination revealed no evidence of active lues. The patient was started on a course of bismuth salicylate. Microscopic examination of a piece of a lymph gland taken out at the time of incision showed entire loss of the normal lymph-node architecture, and rather marked generalized edema. The blood vessels were increased in number and enlarged. Most of these were engorged with red blood cells. The walls appeared somewhat thickened and the endothelial cells had an edematous appearance. The most striking observation was the marked infiltrate of epithelioid cells throughout the section. In places this was so marked that the picture was similar to that of beginning or acute tubercle formation. In places the epithelioid cells made strands, but did not take on true palisade arrangement, as seen so frequently in sections of this



Fig. 1.—Right inguinal region of reported case, showing fistulous opening.

condition and considered by many authors to be most characteristic. Scattered among these cells were many lymphocytes, some polymorphonuclear leukocytes, and a few plasma cells. There were several small abscesses present with a cell type similar to those seen among the epithelioid cells. Cellular and nuclear fragments were present. No giant cells were noted.

As the condition was involuting very slowly, x-ray therapy was instituted which seemed to flare up the condition with an increase in size of the indurated area. Tenderness and considerable more discharge was present, and the process appeared to have extended beneath the inguinal ligament.

On December 4, the patient was seen for the first time in the department of dermatology and presented a large grapefruit-size mass in the right inguinal region. The overlying skin was shiny and tense, and had a deep purplish color. In the center of this was a long opening running parallel to Poupart's ligament. From this considerable purulent tenacious material could be expressed. Associated with this was a generalized adenitis. The spleen could not be felt.

On this date a Frei test was done in the usual manner with an intradermal injection of 0.1 cubic centimeter of the antigen. This antigen was obtained from Doctor Cameron of Omaha. On December 6, forty-eight hours later, the site of injection showed a markedly positive reaction with pustule formation and a wide zone of erythema. On December 11, another Frei test was performed with an antigen sent by Doctor Wein of Chicago. Seventy-two hours later the reaction showed an erythematous firm infiltrated papule about 0.5 centimeter in diameter. About this was a wide erythematous slightly infiltrated halo. According to the patient it had been more marked the day before.

Slowly the discharge had been getting less and the indurated area gradually became smaller, so that by January 11 only a slight amount of pus could be obtained, and from the 18th on there was no longer any discharge present and the sinus had scarred over. Coincident with this the mass has continued to involute. Another Frei test on January 15 was positive.

It is interesting to note that the patient's condition improved following the Frei tests, and it is suggestive that these may have had some therapeutic effect, as has been shown by Wien and others.

## COMMENT

The case reported is clinically typical of lymphogranuloma inguinale, and the diagnosis was confirmed by the use of two different Frei antigens, both of them being strongly positive.

The chief interest of this case, to my mind, lies in the fact that the patient acquired his infection in northern California. Hoffman<sup>17</sup> has reported cases endemic in Southern California.

Other cases have been diagnosed in or about San Francisco in the last few months, but to my knowledge they did not acquire their infection locally. Stewart,<sup>26</sup> at the Marine Hospital, has seen thirteen cases with positive Frei tests, all of these having been in foreign ports recently, except one who received his infection in Los Angeles. Two other patients have come recently under the observation of Brown<sup>27</sup> at St. Francis Hospital. Both of these had just returned from the Orient. Undoubtedly this type of case has, or will prove to be a source of contagion to the inhabitants of ports along the Pacific Coast.

At the December meeting of the San Francisco Dermatological Society, Templeton<sup>28</sup> showed a case of rectal stricture of years' duration in which there was a positive Frei reaction.

In Sacramento, one clinically typical case which was substantiated by the specific test has recently been observed by Schoff.<sup>29</sup> Other cases of this disease are undoubtedly present in the State and its distribution widespread. It is probably going unrecognized as a separate disease and is being considered as chancroidal or gonorrheal bubo.

## CONCLUSIONS

This disease is endemic in California, as has been shown by the cases reported by Hoffman and the one herein reported. Many more cases will come to light if a Frei test is done on all cases of inguinal gland enlargement, particularly if sinus formation is present.

From the recently reported high incidence of positive Frei tests in cases of rectal stricture, this test should be a routine procedure, regardless of whether another infection such as syphilis or tuberculosis is present or not. The same holds true for chronic ulcerations and sinuses about the vulva or perineum.

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## DISCUSSION

EUGENE F. HOFFMAN, M.D. (1100 Mission Road, Los Angeles).—As Doctor Novy has adequately covered the subject under discussion, I shall report some of our experiences on the urological service of the Los Angeles County Hospital.

In summarizing the records of thirty-five cases since March, 1933, we find:

1. Males, twenty-seven; females, eight.
2. Thirty were under fifty years of age; the youngest being fourteen, whose infection was due to the use of an enema tip also used by her infected mother (accidental infection).
3. Americans (whites), sixteen; Mexicans, ten; negroes, seven; Filipinos, two.
4. Twenty-two were single; nine married; two widowed, and two separated.
5. Source of infection in Los Angeles County, twenty-seven; Texas, four; Mexico, one; Minnesota, one; Philippine Islands, one; unknown one.

6. Longest duration of disease, seven years; shortest, twenty-one days.

7. Primary lesion seen in eleven cases.

8. Eleven were Wassermann-positive; twenty-one were negative; three, one or two plus (became negative under tartar emetic therapy).

9. Twenty-six showed systemic symptoms.

10. Bilateral bubos in nine; right bubos in seven; left bubos in ten; rectal strictures in ten (including two males); both rectal strictures and bubos in two (women); maxillary and supraclavicular glands involved in one; fistulae (rectovaginal, vesicovaginal, abdominal) one each, and meningeal irritation (lymphogranulomatous meningitis), one.

11. Twelve bubos went to sinus formation; fourteen did not.

12. Cures, seventeen; under treatment at present, six; deaths, one (glomerulonephritis); failed to return to clinic for check-up, eleven (healing being evident when last seen).

In my previous report, covering the treatment of eleven cases, tartar emetic was considered almost specific. However, we now feel that our best results have been obtained through the intravenous use of antigen, which is superior in results to its intradermal or subcutaneous use.

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SAMUEL AYRES, JR., M. D., (2007 Wilshire Boulevard, Los Angeles).—While cases of lymphogranuloma inguinale are being reported with increasing frequency, it is still far from a common condition. Personally, I have never seen a case in private practice, nor has one ever been presented before the Los Angeles Dermatological Society. Practically all of the patients at the Los Angeles County General Hospital have been admitted on the urological or proctological services. Dr. E. F. Hoffman, who has probably seen more cases of this disorder than anyone in Los Angeles, tells me that there have been approximately seventy cases on the urological and proctological services up to the present time (November 25, 1934).

As Doctor Novy has pointed out, the introduction of the Frei test has been of inestimable value, not only from a diagnostic standpoint, but therapeutically as well. In recalcitrant cases it might be worth while to consider maggot therapy. We have recently had a most gratifying result by the use of maggots in a chronic ulcerative granuloma of undetermined etiology of the thigh of a year's duration. The Frei test was negative in this case, but there were many deep sinuses and undermined margins. In view of the remarkable results by the use of maggots in chronic osteomyelitis, it would seem that they might deserve a trial if the Frei antigen treatment is unsuccessful.

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ANTHONY B. DIEPENBROCK, M. D. (450 Sutter Street, San Francisco).—In 1913 Durand, Nicholas, and Favre published an account of this disease and gave it the name "lymphogranuloma inguinale." At that time they were not familiar with a similar entity, now proved to be the same disease, which had been variously described as climatic bubo, strumous bubo, hypertrophic bubo, tropical bubo, non-venereal bubo, and inguinal poradenitis. Bubo, described with the various adjectives named above, had been seen and reported by Trousseau, Jouet, Guerin, Segard, Martin, Ruge, Gooding, Branfoot, Roegholt, and others, in such places as Reunion Island, Mauritius Island, Indo-China, Tonkin, Madagascar, Sumatra, Zanzibar, Madras, Dutch East Indies, and East Central Africa; hence, it was regarded as a purely tropical disease. Trousseau's description, published in 1865, is perhaps one of the best early works on the subject.

European investigations were given an impetus by the work of Durand, Nicholas, and Favre; but these studies were disrupted by the World War.

In 1925, Wilhelm Frei discovered that individuals afflicted with this disease exhibited a cutaneous re-

action when inoculated with a heated saline dilution of pus, aspirated from a fluctuant bubo. The application of Frei's phenomenon has led to the identification of various types of this disease, previously described as estriomene, climatic bubo, chronic elephantiasis, ulceration of the vulva, inflammatory stricture of the rectum, and the so-called genito-anorectal syndrome. Further, the application of Frei's phenomenon led to the recognition of the world-wide distribution of the disease.

An excellent review of the literature has been presented us by H. S. Stannus in the "Proceedings of the Royal Society," London, 1932.

American interest was given a great impetus by the work of Cole, De Wolf, Van Cleve, Sulzberger, and others.

I agree with Doctor Novy that the term "lymphopathia venerea," coined by Sulzberger, should be generally adopted in writing or speaking of the malady.

My associates, Doctors Rodney A. Yoell, James J. McGinnis, James W. Morgan, and I presented before the San Francisco County Medical Society in April of this year a report of two cases, locally acquired and perhaps the first to be recognized in this State. These patients, husband and wife, have been under our continuous observation since December 6, 1929, and a case report thereon will be printed in CALIFORNIA AND WESTERN MEDICINE.

## CHRONAXIA\*†

ITS THEORY AND APPLICATION TO CLINICAL  
NEUROLOGY—WITH PRESENTATION OF A  
PORTABLE CHRONAXIMETER

By HENRY W. NEWMAN, M. D.  
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DISCUSSION by H. Douglas Eaton, M.D., Los Angeles;  
Samuel D. Ingham, M.D., Los Angeles; Robert Aird, M.D.,  
San Francisco.

THE power of the electric current to cause muscular contraction, when passed through the animal body, has been a part of medical knowledge for a great many years, but it remained for the pioneers of electrodiagnosis, among them Erb<sup>1</sup> and Duchenne de Boulogne,<sup>2</sup> to apply this phenomenon to the diagnosis of certain maladies affecting the muscles and nerves. All of our present clinical knowledge of the reaction of human nerve and muscle to the faradic and galvanic currents, with the variation brought about by injury or disease, can be traced to the work of these men, performed in the middle of the past century.

## VALUE OF ELECTRICAL REACTIONS IN NEUROLOGIC PRACTICE

There is a tendency in modern neurologic practice to put less and less stress on electrical reactions as an aid to diagnosis. I feel that this is due, not to any lack of a need for the information that might be so derived, but to the fact that, despite the tremendous strides which have been made in the refinement of our other diagnostic instruments in recent years, the determination of

\*From the Division of Neuropsychiatry, Stanford University School of Medicine. Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

†From a study supported by a grant from the Rockefeller Fluid Research Fund of Stanford University School of Medicine.

the electrical excitability of nerve and muscle is still frequently undertaken with the same crude apparatus available to our grandfathers. The resultant data, qualitative in nature, and subject to a great extent to the personal interpretation of the individual operator, thus seems unsatisfactory in comparison with the precise methods we are accustomed to expect in other present-day laboratory procedures.

There is no doubt that the determination of electrical excitability can give us information which can be gained in no other manner. It finds undisputed application in hysteria, cases of peripheral nerve injury, peripheral neuritis, and the various types of muscular atrophy and dystrophy, as well as in such conditions as myasthenia gravis and tetany.

With such a wide field of application, it was inevitable that technique should finally be advanced to a point where it was more adequate to meet the situation. The answer to the problem in this case was the application of chronaxia to the neurologic patient. The credit for this work belongs in a large measure to Bourguignon.<sup>3</sup>

#### PRINCIPLE OF CHRONAXIA

The principle of chronaxia (derived from the Greek *chronos*, "time") introduces the factor of the time during which the stimulating current acts, as well as the intensity of that current. The law of Du Bois-Reymond,<sup>4</sup> that the threshold of electrical excitability depended on the intensity of the stimulating current, but was independent of the length of time over which this current was allowed to act, was not successfully disputed until 1892, when Hoorweg,<sup>5</sup> by means of condenser discharges of very short duration, showed that intensities which would stimulate, when allowed to act over a considerable period, were ineffectual when their time of action was reduced to a few ten-thousandths of a second. Weiss,<sup>6</sup> in 1901, confirmed this, obtaining his current of short duration by an ingenious method whereby a pistol bullet was employed to close and open the circuit.

On the basis of this work, Lapicque<sup>7</sup> developed his concept of chronaxia as the length of time, expressed in thousandths of a second, over which a current of twice the rheobasic intensity must act to produce a reaction. The rheobase is the galvanic threshold when the current acts for an infinite period, which for practical purposes need not exceed one second. Working with isolated nerve muscle preparations, he found this value to be quite constant for the species and the anatomical location from which the specimen was obtained.

#### BOURGUIGNON APPARATUS

In 1916 Bourguignon overcame the technical difficulties of the application of Lapicque's apparatus and technique to the intact organism, and was able readily and accurately to determine the chronaxia of human nerve and muscle. Since that time there has been much work by Bourguignon and others in determining chronaxia both in normal and pathological states. Although chro-

naximetry has had a considerable vogue in the neurological centers of France and Germany, in this country it has but recently stepped from the physiological laboratory into the field of clinical neurology. It has the advantage over the older methods of determining the electrical reaction by making available a *quantitative* index of excitability, much less subject to the interpretation of the individual observer, and should thus overcome the main objections to the older methods.

The apparatus used by Bourguignon derives its currents of short duration from the discharge of condensers. The duration of the discharge of a condenser depends on two factors—the capacity of the condenser and the resistance of the circuit through which it discharges. By the employment of an ingenious system of high resistances in series and in parallel with the subject, it is possible to make the resistance of the discharge circuit practically constant, so that by varying the capacity of the condenser the duration of the current can be accurately controlled. Thus, the apparatus consists in essence of a source of direct current, derived from the ordinary house current after rectification and filtering, variable by means of a potentiometer from 0 to 300 volts. This current can be passed either through the discharge circuit directly, as in the determination of the rheobase, or utilized to charge a condenser of suitable capacity at twice the rheobasic voltage. This condenser is then discharged in the determination of the chronaxia.

In order to avoid polarization, the electrodes used are of the non-polarizable variety.<sup>8</sup> This is necessary because the sensitivity of the method would be impaired by polarization occurring with ordinary electrodes, which is not a significant factor with the grosser methods. The indifferent electrode consists of a sheet of silver, electrolytically covered with silver chloride, 10 by 10 centimeters, applied by an elastic retainer to the subject's chest. The active electrode, which is the cathode, is a similarly treated silver disk, one square centimeter in area, mounted on a suitable handle. Both electrodes are kept moist by covering them with gauze saturated with physiological saline solution.

#### TECHNIQUE IN DETERMINATION OF CHRONAXIA

The determination of the chronaxia of a muscle is carried out as follows: the indifferent electrode is strapped to the subject's chest; with the active electrode the motor point is located. For this purpose the galvanic current is utilized, the circuit being made and broken by pressing knob *A* (see Fig. 1), while the intensity is controlled by turning knob *B*. When the motor point is found, the current is reduced by turning knob *B* to the left until a contraction can just be obtained. The voltage read on the voltmeter is the rheobasic voltage. The knob *B* is turned to the right until the voltmeter indicates double the rheobasic voltage, and the chronaxia is then determined by choosing a suitable condenser from the series controlled by

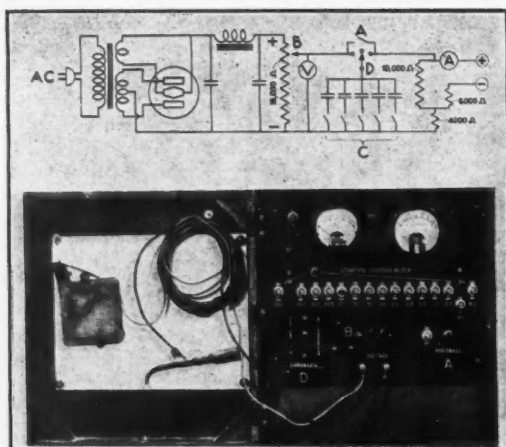


Fig. 1.—Portable Chronaximeter. (a) Rheobase switch. (b) Voltage regulator. (c) Condenser switches. (d) Chronaxia switch.

the bank of switches C, offering a continuous range of combinations from .001 to 11 microfarads; charging this condenser by throwing switch D upward, and then discharging the condenser through the subject by swinging switch D downward. The combination of condensers which will just produce a contraction is found by trial and error. This value in microfarads, as noted on the panel, is multiplied by Bourguignon's constant, 4, which gives the chronaxia of the muscle in sigma, or thousandths of a second.

Naturally, care must be exercised in the location of the motor point, as well as in the observation of the muscular contraction when the threshold is obtained. However, evaluation of the *speed and type of the contraction*, so important in the older methods, is here not essential, being merely confirmatory of the objective findings.

#### VALUES FOR VARIOUS MUSCLES

The values for various muscles in the normal have been carefully worked out by Bourguignon and others, and are remarkably constant from one individual to another. There is a fairly constant ratio of 2:1 between the muscles on the posterior aspect of an extremity and those on its anterior aspect, while the proximal segments of a limb have a shorter chronaxia than the distal segments. Thus Bourguignon gives the following values: for the proximal regions, the anterior muscles show a range from .06 to .14 sigma, the posterior from

.16 to .34 sigma; for the distal regions the values for the anterior muscles are from .16 to .34 sigma, for the posterior group from .40 to .70 sigma. Thus, for practical purposes, *any value over one-thousandth of a second can be considered pathological*. In cases which show the complete reaction of degeneration by the older methods, the chronaxia is found to be from 10 to 30 sigma, while in the muscular dystrophies values up to 80 sigma may be characteristically encountered. Thus we see that the definitely abnormal values are so far removed from the normal range as to make their recognition certain; while, by this more precise method, changes may be recognized long before they would become apparent with the orthodox method.

An example of the evolution of a case of peripheral facial palsy of undetermined etiology is shown in Table 1.

#### REPORT OF CASE

A housewife, age forty years, presented herself at Stanford Clinic with the history and findings of a practically complete facial palsy on the left, of a week's duration. Chronaxia measurements were made at that time, and at intervals thereafter. It can be seen that at the first entry, although the clinical picture was fully developed, there was no alteration in the electrical reaction. Throughout, the chronaxia of the facial nerve itself did not increase significantly, but two weeks after the onset two representative muscles, the frontalis and the orbicularis oris, showed much increased values. The movement in the frontalis returned first, heralded by a decrease in the chronaxia of this muscle, which was later followed by the orbicularis oris. Thus, we see remarkably good correlation between the clinical improvement and the reversion of the chronaxia to nearly normal values.

#### SUMMARY

In summary, it may be said that chronaximetry (which has until recently been considered a procedure confined to the physiological laboratory), can be readily applied to the problems of clinical neurology, and promises to reestablish the determination of electrical excitability in the position of importance which it deserves. It affords an easily obtainable index of the functional state of nerve and muscle which can be gained in no other manner, and provides a quantitative and objective measure of this functional state, which is not possible with the older methods of electrodiagnosis. Thus the determination of chronaxia is a valuable addition to the diagnostic and prognostic armamentarium of the clinical neurologist.

Stanford University School of Medicine.

TABLE 1.—Time After Onset

	One Week	Two Weeks	Three Weeks	Four Weeks	Six Weeks
Clinical course .....	Complete paralysis	Complete paralysis	Forehead improved	Mouth improved	Almost normal
Facial nerve .....	.28 sigma	.28 sigma	.8 sigma	1.2 sigma	1.2 sigma
Frontalis muscle .....	.28	12.0	6.0	1.2	.80
Orbicularis oris muscle...	.60	9.2	8.8	6.8	1.0

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## DISCUSSION

H. DOUGLAS EATON, M.D. (1136 West Sixth Street, Los Angeles).—There is no more important problem in neurology than the determination of the organic or functional character of a given condition. Accuracy in differentiation between a true organic nerve injury and an hysterical paralysis is not only of tremendous value to the patient, but may be of great economic importance. The ability to estimate the severity of an organic nerve injury, and to mathematically record its progress, endows us with real therapeutic insight. The development of a method giving an accurate quantitative valuation of muscle excitability promises to solve these problems for us, and to replace our present unreliable tests.

Doctor Newman's clear and concise article on chronaxia covers the subject completely. It is to be hoped that it will impress upon the general medical profession the fact that such a valuable diagnostic procedure is now practical and available.

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SAMUEL D. INGHAM, M.D. (727 West Seventh Street, Los Angeles).—Doctor Newman has given a very good outline of the principles of chronaxia, and has demonstrated a simple and practical apparatus for its application. For a long time the practice of neurology has suffered from the lack of an exact method of testing motor responses to electrical stimulation to the nerve or directly to the muscle. Even to the present day the most modern textbooks on neurology describe the reactions of degeneration in terms of their response to the faradic and galvanic current. There has been no standardization of faradic coils, and the faradic currents from different instruments show wide variations in voltage and other qualities. Response in muscles from faradic stimulation is quantitative, with no index for measurement. When the galvanic current is used in testing degenerated nerves, the response is both quantitative and qualitative, but still we have no method for measuring the deviation from the normal response. In the chronaximeter we have an instrument by which electrical impulses can be applied to the nerve or the muscle from a series of graduated condensers. We thus have a graduated scale which is easily standardized and which permits a fair comparison of the results obtained by different observers. This method of examination is also sufficiently sensitive to make it useful in the study of motor responses in many conditions not due to primary disease of the nerves and muscles; as, for example, the effect of different drugs and different diseased conditions upon the responses of the neuromotor mechanisms.

✱

ROBERT AIRD, M.D. (University of California Medical School, San Francisco).—In speaking of the clinical application of chronaxia, it is well to remember that

this measurement of the electrical excitability of tissue is but one phase of the excitability of tissue in general. Other modes of excitation are possible, but the accuracy obtainable with the electrical methods as worked out by Lapique and Bourguignon, make this method of particular value for the reasons stressed by Doctor Newman.

It is perhaps interesting to observe further that at the present time the principle of chronaxia is being studied more carefully in the laboratory. An ingenious young Englishman, Rushton, recently questioned Lapique's concept of chronaxia. With carefully controlled studies, he apparently obtained varying chronaxia on the same tissues, the variation depending on the size of the electrodes. He concluded that chronaxia, as ordinarily measured, is not characteristic of the tissue alone, but of the tissue and electrodes. He also brought evidence to show that muscle has two characteristic chronaxia—one probably of the muscle fibers themselves, and the other apparently associated with the innervating nervous elements. This latter would seem to be the one principally involved in the clinical test over the "motor point" of the muscle.

Such facts, however, do not invalidate the practical clinical application of this concept, within the limits proposed by Doctor Newman. As he has stressed, it is undoubtedly a great refinement over the older method. In the hands of a well-trained neurologist, conscious of the possible errors in technique, this method should prove of considerable value over the older methods, both in the diagnosis of doubtful cases and in following the course of neurological cases from a neuromuscular standpoint.

## BREECH EXTRACTIONS IN THE HOME\*

By BERNARD J. HANLEY, M.D.  
Los Angeles

DISCUSSION by Lyle G. McNeile, M.D., Los Angeles; Robert H. Fagan, M.D., Los Angeles; Sterling N. Pierce, M.D., Los Angeles.

IN the period extending from June, 1929, to February, 1934, 5,805 women were delivered in their homes by Unit No. 1 of the Los Angeles Maternity Service. Breech presentations occurred 132 times, 2.3 per cent, which is slightly below the usual incidence. Of these 132 babies delivered, nineteen must be deducted for one or more of the following reasons; prematures, weighing less than three and one-half pounds (1,500 grams); macerated fetuses; monsters or deformities incompatible with life; and those in which the fetal heart was not heard during labor. Of the remaining 113 babies delivered, five were stillborn, or died during the neonatal period, a corrected mortality of 4.4 per cent. There were twenty-four primiparae, with one fetal death, a mortality of 4.1 per cent; and eighty-nine multiparae, with four fetal deaths, a mortality of 4.5 per cent. The average weight of the babies born of the primiparae was 6 pounds 9 ounces (2,950 grams), and of the multiparae 7 pounds 2 ounces (3,200 grams). A comparison of our fetal mortality, in breech presentations, with that of several other clinics is given in Table 1.

\* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

TABLE 1.—*Fetal Mortality in Breech Presentations*

Clinic	Cases	Fetal Deaths	Percentage	
Boston Lying-In .....	235	23	9.7	Corrected
New Orleans Maternity .....	159	16	10	Corrected
Chicago Lying-In .....	250	24	9.6	Uncorrected
Sloane Maternity .....	256	36	14	Uncorrected
Royal Victoria .....	114	6	5.2	Corrected
St. Louis Maternity .....	114	10	8.8	Corrected
Los Angeles Maternity Service..	113	5	4.4	Corrected

It will be noted from this table that our corrected mortality is slightly lower than any other in this group, regardless of the fact that all of our patients were delivered in the homes.

#### MATERIAL IN THIS SURVEY

The Los Angeles Maternity Service gives prenatal and postnatal care to the indigents of Los Angeles City and County, and delivers patients in the homes of those residing within certain boundaries of the city limits. It is a teaching service. Residents are appointed for a six months' period, after having completed not less than a year rotating internship in an approved general hospital. All spontaneous deliveries are conducted by the residents, and all operative deliveries by the residents under the direction of one or more of the attending staff.

In this series, we are considering only those cases which were breech presentations at the onset of labor. The correct diagnosis was made prenatally in thirty-eight of these cases. Studdiford is of the opinion that the diagnosis of breech is missed in about 50 per cent of the cases. Although we see the patients every two weeks in the prenatal clinic, abdominal palpation is done only approximately every six weeks. This may account for such a small number being diagnosed prenatally. We do not attempt external version. McNeile feels that this is often a dangerous procedure, is usually ineffective, and should not be taught in a clinic, where medical students are always present.

The general policy in the Los Angeles Maternity Service is to hospitalize cases which show marked evidence of toxemia or hemorrhage in the last trimester. This results in some breech presentations being sent into the hospital which would otherwise be delivered in the district, and may account for our rather low incidence of breech presentation.

#### PROCEDURES IN BREECH PRESENTATIONS

When a patient is in labor, in which the resident makes a diagnosis of breech presentation, one of the attending staff is notified, and the patient is seen by him. If he confirms the diagnosis, the set-up for operative delivery is prepared. This is shown in Figure 1. We use the kitchen table for our operating table. The method of procedure then depends upon the type of breech presentation, and the progress of labor.

We classify breech presentations and define them as follows:

1. Frank breech: thighs are flexed on the abdomen and the legs extended on the chest, the feet lying along the head.

2. Complete breech: the thighs flexed on the abdomen and the legs flexed on the thighs and crossed, such that the buttocks and feet present simultaneously.

3. Footling: when one or both feet present at the internal os.

A frank breech, if engaged, is allowed to continue in labor until dilatation is complete, and the breech is on the perineum. With each pain, the breech is then guided until it is through the vulva and the lower extremities have been extracted. We then proceed with our extraction, as will be described under the method of breaking up a breech. If the breech is not engaged, and the membranes are ruptured, two hours are allowed after full dilatation, provided there is no fetal or maternal distress. If there is no progress, the patient is then deeply anesthetized with ether; the breech is broken up, and an extraction done. In breaking up a frank breech presentation, we have found Pinard's maneuver of the greatest advantage in getting both feet down. When both feet are delivered, traction is made in the axis of the birth canal until the breech sits in the hollow of the sacrum. Here we rest for a moment. The breech is then rotated, bringing the sacrum anterior. The sacrum is then covered with a sterile towel and grasped with both hands; traction is then made in the axis of the birth canal until the umbilicus is delivered through the vulva, at which time a ten-centimeter loop of cord is pulled down. The operator then continues traction, with a gentle spiral motion back and forth, until a scapula is fixed under the symphysis. The anterior arm is then extracted by gentle sweeping motion over the face and chest. The fetus is then rotated through 180 degrees, keeping the back anterior, and the second arm, which was posterior, is then brought under the symphysis and extracted in a manner similar to the first. The operator now introduces one hand into the birth canal and straddles the fetus over the same arm. Flexion of the head is increased by the introduction of two fingers into the baby's mouth. Suprapubic pressure is then made in the axis of the birth canal by the other hand of the operator. Two impor-

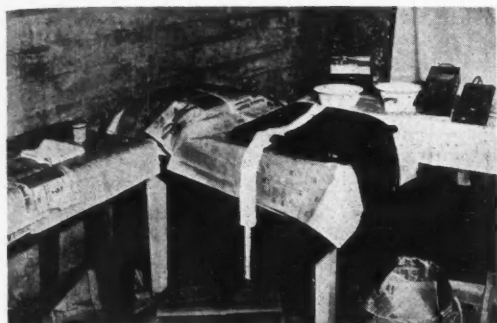


Fig. 1.—Photograph of operative set-up in home.

tant points are to be remembered at this time: First, the fingers in the baby's mouth are not for traction; second, the arm on which the baby is straddled is not to be raised so as to produce dangerous angulation. If undue resistance is met on the pelvic floor, an episiotomy is done and, if necessary, forceps applied on the after-coming head. It is our policy to explore the lower uterine segment and examine the cervix following a breech extraction in which there were any intra-uterine manipulations.

In complete breech the same principles are employed as in a frank breech, except that when the breech comes on the perineum the feet are grasped and the extraction is done. This type of case is more favorable than the frank breech, because of the ease with which the feet can be grasped.

Footling presentations are the most difficult problems, because we are usually dealing with the undilated cervix, and we feel that the undilated cervix is a more common cause of difficulty in extraction than the bony pelvis. With one or both feet presenting, if the cervix is effaced and dilatable, we complete the dilatation manually, and do an extraction. If the cervix is not dilatable, the general policy would be to send the patient into the hospital for introduction of a bag.

#### FETAL DEATHS

In regard to our fetal deaths, there were two in which difficult deliveries were directly responsible.

#### REPORT OF CASES

CASE 1 (No. 27610).—White, primipara, age seventeen, with a general contracted pelvis, frank breech presentation and membranes ruptured at the onset of labor. After thirty-six hours of labor, in which the cervix was fully dilated for two hours with no progress, the breech was broken up and a difficult extraction was done. Simpson forceps were used on the after-coming head. The baby, weight 9 pounds 2 ounces (4,100 grams), was stillborn. Autopsy showed a ruptured tentorium cerebelli, with considerable extravasation of blood.

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CASE 2 (No. 42637).—Mexican, age twenty-eight, para three, gravida 4; three spontaneous deliveries previously, with one stillborn baby. She had a general contracted pelvis, with a frank breech presentation. She was in labor eleven hours, in which the cervix was fully dilated for two hours, with the membranes ruptured, and no progress. The breech was then broken

up and a difficult extraction done. An eight-pound (3,600 grams), stillborn baby was delivered. There was no autopsy.

We were unable to account for the fetal deaths in the remaining three cases, as the deliveries were not difficult. There were no autopsies, so the deaths must be charged against the method of delivery.

#### SUMMARY

A résumé of 113 breech extractions done on the Los Angeles Maternity Service is given.

There was a corrected fetal mortality of 4.4 per cent.

Breech presentations can be safely handled in the home, with no greater fetal mortality than in a hospital.

We feel that breech presentations should not be delivered by cesarean section until a thorough study of the pelvis has been made, and a disproportion shown to exist between the passage and the passenger.

The cervix must be fully dilated and paralyzed before attempting an extraction.

The extraction must be done slowly, and all well-established principles must be followed.

Forceps must always be available, in case of difficulty with the after-coming head.<sup>†</sup>

1930 Wilshire Boulevard.

#### DISCUSSION

LYLE G. McNEILE, M. D. (523 West Sixth Street, Los Angeles).—There seems to be an almost irreducible minimum fetal mortality in breech deliveries of about 8 per cent, and this in clinics where the skill of the men working and the degree of intern supervision is at its maximum. The corrected mortality of 4.4 per cent on the Los Angeles Maternity Service is therefore remarkably low. There are two possible explanations. First, the policy practiced on the Maternity Service is that followed in the private practice of the men supervising these outpatient deliveries, *i. e.*, upon completion of dilatation, the breech is broken up and delivered. This, as we all know, is contrary to the usual teaching, and is no doubt open to criticism. However, in a large series of cases in private practice maternity service and the Los Angeles General Hospital services, we have concluded that this method in the hands of the trained obstetrician gives the best results. We have never taught this as a practice for the general practitioner without special obstetrical training. Second, the supervisors of the Maternity Service never hesitate to deprive the outpatient staff of deliveries when the question of safety for mother and baby arises; and cases are occasionally hospitalized, that might subsequently have raised our fetal mortality if delivered in the home. I refer particularly to the footling presentation in primipara in which dilatation is incomplete after a prolonged first stage and in which the cervix is of such consistency that it seems better to insert a complete dilatation bag. We believe that the cervix is the most frequent cause of infant mortality in breech deliveries.

Complete dilatation of the cervix, deep anesthesia and an unhurried rigid adherence to correct technique, with a complete understanding of the obstetrical anatomy of the pelvis and the mechanism of breech labor, are the fundamentals that lower fetal mortality in breech extraction.

<sup>†</sup>The author wishes to thank Dr. Lyle G. McNeile, director of the Los Angeles Maternity Service, for permission to use the records, and his colleagues, Dr. Philip A. Reynolds and Dr. R. D. McBurney, for their assistance in a number of cases here reported.

ROBERT H. FAGAN, M. D. (1136 West Sixth Street, Los Angeles).—The technique described for breech extractions by Doctor Hanley is, in my estimation, the safest of all procedures which have been described for this operation. Of all obstetrical procedures, I believe that the breech extraction is the most feared and the least understood by many physicians. Doctor Hanley's low fetal mortality rate is certainly worthy of comment. Particularly is this true when one considers that these deliveries were executed by many individuals in the process of their obstetrical training. It is doubtful if an obstetrician in private practice has as remarkably low fetal mortality rate in his breech deliveries. I should like to ask if many of the breech presentations are hospitalized for delivery? If so, it would be interesting to compare the mortality rate of those delivered in the hospital and in the home.

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STERLING N. PIERCE, M. D. (1930 Wilshire Boulevard, Los Angeles).—In this series of breech presentations, which were delivered on the City Maternity Service of Los Angeles and reported by Doctor Hanley, we are shown a mortality rate which is indeed very low, in fact, the lowest to be reported in six of the outstanding clinics of this country and Canada. It must be remembered that our City Maternity Clinic is strictly a teaching service, where training is given residents and medical students. This report shows the painstaking way with which the Service has been supervised.

There is little to add to what Doctor Hanley has said, but some points should be particularly stressed. First, in the handling of any breech delivery, the operator must be able to evaluate the comparative size of the passage and the passenger, for a successful delivery from below. Second, that a woman in labor with a breech presentation requires the same careful watching as a vertex presentation. Both mother and babe should be observed closely with no interference so long as labor progresses favorably. By no interference, we mean that the B. O. W. be kept intact, if possible, until dilatation of the cervix is complete.

Complete dilatation, or its equivalent, is essential before any breech extraction is attempted. In cases when the condition of either the mother or the baby indicates immediate delivery, one should resort to either mechanical means of dilating the cervix, or incisions.

Doctor Hanley also stresses the fact that a breech presentation should be allowed to progress normally until the lower extremities have been delivered. His method of delivery is worthy of careful study, particularly the extraction of the arms; since, although contrary to textbook teachings, it will cause less injury to the arms. Stress is also laid on the method of handling the after-coming head; namely, the head is maintained in flexion by inserting the fingers in the baby's mouth, and delivering the head by making pressure from above. Forceps on the after-coming head is a safer procedure, if any resistance is met at the bony pelvis.

However, it is my belief that episiotomy should be a routine procedure in primiparae. Another very important point which few understand is that time is not a particular element in breech extraction. Many babies have been lost or seriously injured by the operator endeavoring to complete delivery in a certain allotted time. While a breech should be delivered as rapidly as possible, gentleness and art are the first principles to be considered.

When we consider that this series was delivered on the old kitchen table on a teaching service, I feel that Doctor Hanley has contributed a great deal, particularly in showing the profession that every breech presentation is not necessarily an indication for abdominal delivery.

## CALIFORNIA MEDICAL-ECONOMIC SURVEY\*

EXCERPTS FROM THE PRELIMINARY REPORT  
OF JANUARY 16, 1935

### PURPOSE AND SCOPE OF THE STUDY

WHEN the staff of the California Medical-Economic Survey took up duties last August, it outlined a fourfold purpose of the research work to be undertaken. The staff proposed:

1. To ascertain the amount paid by various classes of income receivers in California for medical and dental care.
2. To determine the ability of various income groups in California
  - (a) To pay for health and dental services.
  - (b) To secure adequate medical and dental care.
3. To review methods of meeting the problem of medical care in various localities within the State, in other states, and in other countries.
4. Finally, after various methods of meeting the problem of medical care elsewhere have been reviewed,
  - (a) To set forth all possible alternative methods of meeting such problems as the survey reveals exist within the State, and
  - (b) To make constructive proposals based upon the findings of this study.

Almost five months have elapsed since this outline of study was made, and in view of the pressure of interest and developments the field to which the study pertains, it is quite appropriate and necessary for a pause to be made during which time the staff can summarize its activities and accomplishments to date, and present several significant preliminary findings together with appropriate recommendations.

The objectives to which the staff is committed necessitate very extensive investigation and study. A mass of data has been gathered in the last few months, but the work of tabulation and analysis only began recently. It is therefore necessary to emphasize that the tables presented in this Pre-

\*Editor's Note.—The House of Delegates of the California Medical Association, at the annual session held at Riverside, in April, 1934, authorized the appointment of a special Committee of Five for the Study of Medical Care, and instructed it to make a medical-economic survey of California. This committee appointed consisted of Doctors William R. Molony, Chairman, Los Angeles; Harry H. Wilson, Secretary, Los Angeles; Alson R. Kilgore, San Francisco; Robert A. Peers, Colfax, and Rodney A. Yoell, San Francisco.

Paul A. Dodd, Ph. D., Assistant Professor of Economics in the University of California at Los Angeles, was appointed director of the survey; and Gordon S. Watkins, Ph. D., also Professor of Economics in the same university, was made consulting economist.

An Advisory Council, as well, was provided for, made up as follows: John B. Canning, Ph. D., Professor of Economics, Stanford University; Arthur G. Coons, Ph. D., Dean of Men and Associate Professor of Economics, Occidental College; Rockwell D. Hunt, Ph. D., Dean of the Graduate School, University of Southern California; The Reverend James J. Lyons, S. J., President of the University of Santa Clara; and Samuel C. May, Ph. D., Professor of Political Science and Director of the Bureau of Public Administration, University of California. At the same time, offices in which the administrative work could be carried on were established at the Beverly Professional Building, 9625 Brighton Way, Beverly Hills, California.

On January 16, 1935, Director of Survey Dodd submitted to the Committee of Five a Preliminary Report of 91 typewritten pages, copies of which were sent to the officers and component county societies of the California Medical Association, and to the delegates who were called in special session at Los Angeles on March 2 and 3. Later a Supplementary Report of some 30 pages was issued. Some excerpts from the first report are printed on this and the following pages, and to these extracts the attention of members of the Association is called, in connection with the reports adopted at the special session of the House of Delegates on March 3, 1935, as presented on page 194.

The excerpts printed under the starred title are from a report by Director Dodd's Survey Staff to the Committee of Five.

liminary Report are subject to later modifications. The labor involved in this type of work is far more extensive than at first might be realized; and adequate final analysis is dependent upon sufficient time and financial resources. With this warning in mind we turn first to a review of the research staff's activities and accomplishments up to the present, and an outline of tentative plans for the scope of the final study.

The field survey phase of the staff's study has been limited to the State of California; but the broader economic aspects of the problem of medical and dental care, involving a study of methods and principles, has been unlimited in scope. Thus, the factual data relating to the health and economic conditions of families, to doctors, dentists, hospitals, clinics, etc., have been purposely limited (in the main) to individuals and organizations within the State. But, on the other hand, all the data and information relating to methods of meeting public or private health needs have been secured wherever such information has been available. In other words, the statistical picture presented is one of conditions existing within California, while the results of experience and experiment elsewhere have been studied wherever it has been possible to secure records of them.

#### TYPE OF DATA BEING GATHERED

The study is being based upon two types of data. One is composed of schedules<sup>1</sup> calling for information from the public and from the various professional groups and institutions related to the broad fields of medicine and dentistry. Two forms of general schedules have been used in recording information from the consumers of medical and dental services: the first for use by field visitors in personal contact with the individual family, and the second for use by the family indirectly through the mails or through some representative organization. Upon these two forms information has been obtained concerning the economic and health conditions (such as income, principal ailments, treatment, expenditures, etc.) of families throughout the State.

In addition to these general schedules for the public, a carefully planned schedule was constructed for recording data to be secured from the doctors, another for the dentists, another for the hospitals of the State, and still another for clinics.

All of these schedules were drawn up with the greatest possible care. Each form was compared with those used previously in similar studies; each was submitted to its respective group of doctors, dentists, hospital executives, or clinic heads for criticisms and suggestions. Furthermore, these forms were submitted also to each member of the Advisory Council and to the statistical research departments of both the State and the Federal Emergency Relief Administration. Thus, they

were finally approved by these qualified individuals before being adopted by the staff for actual use. It might also be added that in the case of the general schedule actual sample test runs were made in the field before the final forms were printed so that as many of the indefinite questions as possible might be omitted, and proper final revisions might be made before the forms were put to final use.<sup>2</sup> But still several advisable alterations escaped the attention of the staff, not to be discovered until the field work was almost completed. No doubt a similar test run on the other forms would have proved valuable in indicating the desirability of changing the wording of several questions, and dropping several others from the forms. But in general they would have remained essentially the same. Certain obvious omissions of questions from the general schedule have been made deliberately, in order to minimize duplications and coordinate the information requested on the staff's schedules with that obtained by other studies of a somewhat similar nature.<sup>3</sup>

The second type of material being collected is composed of information relating to other phases of the problem of medical-economics, such as the details of hospitalization plans, health insurance plans, expressions of opinion from individuals and organizations, research material from other studies, the original questionnaires used in previous surveys, information from public health agencies, and insurance companies. This material, the staff feels, is needed for proper evaluation and interpretation. While this list of the material being used is not complete, it may serve to indicate the type of data on which the staff is working.

#### GENERAL SCHEDULES SENT OUT

The intensive research program suggested above has necessitated a scientific method of procedure and as effective an administrative organization as possible to make certain that such a procedure was being followed. The first step, it was felt, was concerned with the selection of sampling areas throughout the State for use of the general schedule. The staff believed that if a one per cent random sample were obtained from the family population of the State, a picture gained from such a sample would be representative of the State as a whole; and if carefully taken would be acceptable for the purposes of this study.

An application for a blanket grant from the State Emergency Relief Administration to aid in the undertaking of this work throughout the State would have called for the establishment of a new precedent which would have set aside individual county autonomy in the handling of appropriations. This was found to be inadvisable and impracticable, and a different procedure for the organization of the field work of the survey was adopted. Under this new plan the State was di-

<sup>2</sup> Copies of all forms used will be incorporated in the Final Report.

<sup>1</sup> The forms used in this study are referred to as "schedules" rather than "questionnaires"—the distinction being principally one of set-up. A schedule is usually formidable in appearance, asking for much of the information to be filled out in tabular form; while a questionnaire is usually made up of simple questions calling for short and positive or negative answers.

<sup>3</sup> It was particularly important to coordinate the work of this study with that of the depression and health survey (a California study being made under the direction of Miss Margaret Klem). Such questions as those relating to the division of medical and dental payments were omitted from our schedules because this information was being obtained in Miss Klem's study.

vided into counties, and an organization for the California Medical-Economic Survey was set up in each county included in the program. The staff recognized that the value of any survey which utilizes the principle of random sampling depends directly upon the care exercised in planning and executing the sampling process, and it has made every effort to develop a method of selecting sample families which, while being as simple and objective as possible, would still constitute a representative and unbiased cross section of the families throughout the State. In order to be doubly certain that this representative sample was being obtained, classifications permitting a close comparison of the staff's figures with those of the United States Census Bureau have been followed.

For the field work on the general schedule, then, the primary division of areas (for the purpose of sampling) was according to rural or urban residence of the family. Then followed the classifications of race and occupations. When these three items were taken into consideration, the sampling process became essentially a matter of geographical subdivision according to population densities. Since a one per cent random sample was desired, the best way to obtain this sample would have been to secure a one per cent sample from every town and village, and from each small unit of rural section in every county of the State. As indicated above, however, this was impossible for obvious reasons.<sup>4</sup> Instead, a selection of certain towns and villages and rural districts having geographic, economic, racial, and occupational characteristics quite representative of the county as a whole was made in twenty-six of the fifty-eight counties throughout the State.<sup>5</sup> Field work was thus concentrated in certain parts of the twenty-six counties covered, these counties in turn representing a total of almost 94 per cent of the population (1930) of the State.

#### SUMMARY OF FIELD ACTIVITIES

Reference to the field activities will show that a total of 682 workers was engaged for the field work throughout the State, and that seventy-five have been employed in the central office on relief work. Of the 682 employed to carry on field operations, twenty-nine were supervisors, forty-three were office stenographers, local editors, and clerks; and 610 were field visitors. Some difficulties were encountered in the selection and training of such a large staff in a short time.<sup>6</sup> The fact that every field visitor engaged was limited to a work-relief budget and was paid by the Relief Administration created many difficulties in regard to the selection and qualifications of field personnel. In some counties, as in San Francisco, it was necessary to limit the time each worker spent in the field on the survey to only one or two days each week in order

to comply with the regulations of the County Relief Administration. In San Diego County, on the other hand, field visitors were allowed anywhere between fifty and one hundred hours of work per month. This permitted one group of workers to complete the whole survey in that county. In Los Angeles County, after the county officials had granted a special request of the staff, the field visitors were allowed to work out (without restriction as to the maximum number of hours per day or days per week) their total monthly work order budget consecutively and without interruption. Nevertheless, in Los Angeles County a total of 297 field visitors were selected and trained to do the work originally planned for about 135 full-time workers. This was made necessary, as indicated above, because of the limited work allowances made to the State Emergency Relief workers during any one month.

Only a few of the problems bearing upon the field work of the survey have been indicated here. In view of the large labor turnover, the rapidity with which the survey organization has been built up, and the extent of the territory over which it has been spread, the accuracy of the results obtained may be questioned by some. A defense does not fall within the bounds of this brief preliminary report, and yet the staff feels that such a criticism is serious enough at least to be recognized. Suffice it to state here that all of these matters have received the closest scrutiny of the staff; and that while they may be serious, enough precautionary measures have been taken in advance to enable them to be dealt with satisfactorily. A system of rechecks has been developed so that each schedule filled out in the field has been edited by the county supervisor or his assistant before being turned in at the central office, where it has been double-checked completely by two different editors. Again, the accuracy with which the individual workers have obtained information is being checked by revisits to a number of the families originally giving the information. These and other rechecks have disclosed a number of inaccurate schedules, but the thorough application of the rechecks should permit the reliability and accuracy of the final results to be accepted without serious question.

However exhaustive the staff's efforts may be in rechecking, careful examination has demonstrated that information presented in answer to several questions on the schedules, at best, is only a guess on the part of a majority of the informants. Information of this quality, therefore, must be omitted from tabulations and analysis. This is particularly true of information concerning the family budget, where editing has shown that not more than one or two families out of one hundred keep a budget accurately enough to give proper proportional expenditures. Schedule returns from doctors, dentists, hospitals, and clinics have also disclosed several questions, answers to which cannot be tabulated for the same reasons. The staff mentions these cases only for the sake of emphasizing the care with which final interpretations are to be made.

<sup>4</sup> The cost of securing the sample in some of the more inaccessible counties would have proved to be prohibitive. The primary consideration, however, in including any county in the survey was not one of cost, but rather one of population and representativeness.

<sup>5</sup> For list of counties covered, see Appendix.

<sup>6</sup> The duration of field work has ranged from ten days in Imperial County to ten weeks in Los Angeles County, depending upon the size and population of the county in question.

## SCHEDULES MAILED OUT

A second set of primary data has been obtained in answer to schedules sent out through the mails. A glance at the table below will indicate the extensiveness of this program.

TABLE 1.—Summary of Schedules Mailed Out (to January 1, 1935)

Mailing	M.D.	D.D.S.	D.O.	Hospitals	Clinic	Total
Original	9,236	5,669	1,314	460	416	17,095
First follow-up	7,240	5,056	1,070	433	300	14,099
Second follow-up	6,700	4,230	—	300	—	11,230
Total	23,176	14,955	2,384	1,193	716	42,424

Every person whose name appears in the March, 1934, Roster of Physicians and Surgeons, and in the September, 1933, Dentists' Directory, as well as every hospital and clinic throughout California, was solicited by means of a form letter with an enclosed original schedule. After an adequate waiting period, a first follow-up was addressed to those who had not returned a card stating that a schedule under separate cover had been filled out and mailed to the office of the survey. Where the staff felt it advisable, a second follow-up was sent out. When the coöperation of professional associations was lent, misunderstandings in regard to the purpose of the survey were cleared away, and thus the number of follow-ups that it was found necessary to send out was reduced considerably.

In addition to the mailing program indicated in the table above, the staff had printed a total of 26,000 direct mailing schedules which have been or are being distributed by three methods to individual families. Part of these schedules were stamped and addressed to certain mail-carrier routes in selected city districts and inaccessible villages not covered by field visitors. Another portion was sent out through unstamped personal deliveries made by field workers in metropolitan districts of Los Angeles and San Francisco not covered by the regular field visitors. The remaining portion is being distributed to members of the Parent-Teachers Association through officials of the various association units. This work is frankly admitted to be experimental, and while the returns are being tabulated separately from the other schedules, the staff feels that the checking made possible in this way more than justifies the relatively small additional expenditure involved in having these forms printed and distributed.

Many other inquiries have, in the course of this investigation, been addressed to groups such as the county health officers, presidents of civic organizations, representatives of commercial and labor organizations, employers, and others.

## RESULTS OF THE SURVEY

At this early stage, a brief presentation of some of the data made available by the survey is all that can be attempted. The following tables show the total number of responses received and compares the percentage of responses in this study with those obtained in previous surveys.

TABLE 2.—Summary of Schedule Receipts (to January 12, 1935)

Schedules Received	Complete	Incomplete	Total
General schedules from field visitors	19,601	609	20,210
General schedules through mail	1,157	25	1,182
Doctor schedules—M.D.	3,112	296	3,408
Doctor schedules—D.O.	646	59	705
Dentist schedules—D.D.S.	1,828	85	1,913
Hospital schedules	192	33	225
Clinic schedules	97	49	146
*Total	26,633	1,156	27,789

\*Incomplete schedules are here classified as those having practically no information in usable form on them. Thus the number classified as complete will actually be less, considerably so in some cases, where tabulations on the answers to specific questions are being run, and the number included in the total tabulations of questions will vary according to the completeness of the answers to individual schedules.

From a study of the table below, it will be noted that, to date, 34 per cent of the doctors of medicine communicated with have sent in a fairly complete answer. When the total returns including

TABLE 3.—Percentage Replies in California Medical Economic Survey Up to January 12, 1935

Classifications	Number in California Originally Contacted	Complete Schedules Received	Per Cent Replying
M. D.	9,236	3,112	34
D. O.	1,314	646	49
D. D. S.	5,669	1,828	31
Hospital	460	192	42
Clinic	416	97	23

296 incomplete schedules are counted in, this percentage is increased to thirty-seven. In the two surveys made by the Committee on the Costs of Medical Care (with the coöperation of the American Medical Association), a total of approximately 40 per cent of the doctors of medicine finally responded;<sup>8</sup> while in the Michigan study approximately 50 per cent responded,<sup>9</sup> and in the Tacoma, Washington, study to date a total of about 25 per cent have replied. It should be added that the 34 per cent response here referred to is based upon the total number of doctors of medicine listed in the Directory of the Board of Medical Examiners (1934), supplemented with an up-to-date list of those licensed by the board on or before April 1, 1934. Judging from replies explaining why schedules are not being returned, these lists have contained hundreds of names of doctors of medicine who have retired from active practice. If this is true the real percentage return increases accordingly.

It might be interesting in passing to note that the 31 per cent response from the dentists received from various parts of the State compares with a 62 per cent reply received in answer to a questionnaire sent out in 1930 by the American Dental Association. These forms were sent out to a one-in-four random sample from an alpha-

<sup>8</sup> Maurice Leven, *The Incomes of Physicians*, Chicago, University of Chicago Press, 1932, Chapter II.

<sup>9</sup> Michigan State Medical Society, *Report of the Committee on Survey of Medical Services and Health Agencies*, 1933, page 69, and Chapter IV.

<sup>10</sup> From a special communication concerning the survey being conducted by the Foundation for Social Research in Medical Care in Tacoma, Washington, of which John Schlarb, Jr., is director.

betized list of 35,700 names.<sup>11</sup> However, returns from all groups covered by the California Medical-Economic Survey are still being received, so these percentages should not be accepted as final. Even so, the returns received to date appear to be entirely adequate and representative of the various professions and groups concerned.

#### FINANCIAL APPROPRIATIONS

The detailed work of coding, editing, and punching is progressing satisfactorily, and there still remains a sufficient balance from appropriations of the State Emergency Relief Administration to see this work properly completed. For a summary of information concerning appropriations both from the Relief Administration and from the sponsors of the survey, reference is here made to the financial summary presented at the end of this report. It will be noted that total appropriations of some \$55,425.42 have been secured from the State Emergency Relief Administration (through coöperation of the California State Board of Health), and expenses amounting to approximately \$17,260.35 for proper direction<sup>12</sup> and \$11,382.96 for supplies and staff overhead expenses are being met mainly by the California Medical Association. Within the last three weeks the California Medical Association has approved an additional request for approximately \$5,000, and the Los Angeles County Relief Administration has approved one for \$6,270. This has been done in order to permit the proper and thorough completion of the field and research work. These Relief Administration grants, together with the extensions of appropriations from the California Medical Association, are making possible a far more comprehensive and complete final report than was originally planned.

#### PLANS FOR COMPLETING THE FINAL REPORT

It is hoped that the brief sketch contained in the preceding pages may serve to emphasize the fact that the work of the staff is still far from complete. A volume of factual data now lies in the central office of the survey, where it awaits accurate classification and correlation before complete analyses and interpretations can be made. In fact the data attached to this Preliminary Report, it must be remembered, constitute only a very limited sample of what can be compiled from the schedules and other data already available. In interpreting this material the members of the staff plan to make thorough tests of reliability and frequent comparisons between the results of this study and the results of others previously completed. At the same time, they are not unmindful of the qualifications that must be attached even to the final results. Work toward its completion is being hastened as fast as accuracy and thoroughness permit, and should end some time this spring.

<sup>11</sup> The American Medical Association list was composed of 8,923 names selected by taking every fourth name appearing. Usable data with respect to incomes were supplied by 59 per cent of the total number communicated with. See Maurice Leven, *The Practice of Dentistry and the Incomes of Dentists in Twenty States, 1929*, Chicago, University of Chicago Press, 1932.

<sup>12</sup> This includes payroll needs for twenty-four full-time workers and nine part-time workers during the peak of the field work in November and December.

#### PURPOSE OF PRELIMINARY REPORT

Before turning to the two main divisions of the report that follow, it might be well to summarize the objectives of the Preliminary Report. They are, briefly, four in number, the first of which has been briefly covered in this Introduction:

1. To review the staff's activities, summarizing the results to date and indicating the scope of the Final Report.
2. To present and explain some significant preliminary tabulations (Part II).
3. To review briefly some of the more important principles and methods of health insurance (Part III).
4. To set forth certain qualified conclusions and recommendations, pending the completion of the Final Report (Part IV).

It is hoped that the foregoing discussion will have made clear the limitations of this Preliminary Report due to the incompleteness of the data incorporated in it and the fact that more time is required to enable a complete analysis of all the data to be made and final conclusions to be reached. In spite of these limitations the trends or tendencies revealed, even in this report, are not without significance.

#### SELECTED FACTS FROM THE REPORT

Thirty per cent of the population of California live on farms or in communities of less than 5,000 inhabitants.

California had, in 1927, a higher proportion of physicians to population than any other state in the United States, or any nation in the world.

In California, in 1934, there were 537 persons per doctor of medicine in six metropolitan counties, while for the State as a whole, there were 625 persons per doctor of medicine.

In 1934 doctors of medicine in the State were almost twice as numerous as dentists, three times as numerous as chiropractors, and seven times as numerous as doctors of osteopathy.

The proportion of practitioners in Los Angeles in 1934 was four times as great as in communities of less than 5,000.

Over 40 per cent of all practitioners in Los Angeles and San Francisco are doctors of medicine, and almost 25 per cent are dentists.

Rural areas including small urban centers have a greater hospital bed capacity in proportion to population than have urbanized communities.

Patients with ordinary illnesses, requiring the facilities of general, maternity and children's hospitals, have access to only half the hospital bed capacity of the State.

Three hundred and ninety-nine hospitals reported a total bed capacity in 1933 of 61,053 beds, admitted 520,991 patients during the year, and had an average occupancy of 48,017 patients.

In 1933 all hospitals in California operated at about 79 per cent capacity. Government-owned hospitals operated at almost 90 per cent capacity, and non-government-owned operated at 53 per cent capacity.

The bed capacity of non-government-owned hospitals declined slightly from 17,362 in 1933 to 17,345 in 1934, while the bed capacity of government-owned hospitals increased from 43,691 in 1933 to 46,181 in 1934.

The number of patients admitted to non-government-owned hospitals in 1933 was almost as large as the number admitted to government-owned, while the bed capacity was less than half as large.

Almost one-third of the doctors of medicine earned less than \$2,000 in 1933. Half of them earned less than \$3,000, and three-fourths less than \$5,000.

Approximately half the doctors of medicine reporting for both 1929 and 1933 earned less than \$6,000 in 1929, while three-fourths earned less than \$6,000 in 1933. Twenty-five per cent earned over \$9,000 in 1929 and only 10 per cent in 1933.\*

In 1933 one-half of the osteopaths had incomes of less than \$2,000. Eighty-six per cent of them earned less than \$4,000.

Five per cent of the doctors of osteopathy earned over \$10,000 in 1929. None were in this income class in 1933. Fifty-one per cent of the osteopaths in 1929, and 85 per cent in 1933, earned less than \$4,000.

Dentists appear to have earned less than doctors of medicine but more than osteopaths, in both 1929 and 1933.

In 1933, 34 per cent of the dentists earned less than \$2,000, 61 per cent earned less than \$3,000, and 78 per cent earned less than \$4,000.

Only 13 per cent of the dentists reporting incomes for both 1929 and 1933 earned less than \$2,000 in 1929; but in 1933, the proportion was 30 per cent. Forty-four per cent earned less than \$4,000 in 1929, as compared with 76 per cent in 1933.

The depression seems to have affected the incomes of dentists and osteopaths more than those of doctors of medicine.

Eighty-one per cent of the 4,882 families upon which information has been tabulated reported annual incomes in 1933 of less than \$2,000. Of these 26 per cent had incomes ranging from \$2,000 to \$1,200, and 55 per cent had incomes of less than \$1,200.

Out of the 19 per cent of families found to have incomes of over \$2,000 in 1933, 11 per cent had incomes ranging from \$2,000 to \$3,000, 5 per cent had from \$3,000 to \$5,000, and nearly 3 per cent had incomes of \$5,000 and over.

Of all persons in the income class under \$1,200, 17.3 per cent required medical attention in contrast to the 8.6 per cent of persons in the income class of \$5,000 and over.

No significant differences in the need for medical care appear among the income classes between \$1,200 and \$5,000. The proportion of persons needing medical attention who received a diagnosis is smallest in the low income classes and greatest in the high income classes.

Twelve and three-tenths per cent of all persons in the income class under \$1,200 were reported as requiring dental attention against 4.4 per cent in the class of \$5,000 and over.

The proportion of persons needing dental attention who received a diagnosis varies with income, and relatively more sharply so than those reporting a need for medical attention who received a diagnosis.

Only 21.2 per cent of the income class under \$1,200 needing dental attention were receiving it, while 60.3 per cent of those in the \$3,000 to \$5,000 class who reported the need for treatment were receiving it.

Twenty-five and seven-tenths per cent of all families studied reported no medical and dental charges had been incurred within the period September 1, 1933, to September 1, 1934. This does not necessarily mean, however, that they were receiving no medical care, for some may have received free clinical attention or free services from members of the professions.

The proportion of families reporting no charges incurred during a one-year period varies from 33.4 per cent in the group under \$1,200, to 10.4 per cent in the group of \$5,000 and over.

In each income class there are both large groups of families experiencing high charges and large groups experiencing low charges.

Of the families receiving less than \$1,200 in 1933, 15 per cent reported that charges ranged between \$20 and \$40; 8 per cent reported charges of \$100 to \$200;

3.8 per cent or 103 families reported charges of between \$200 and \$500; twenty-three families reported charges between \$500 and \$1,000, and nine families reported charges of over \$1,000.

Medical charges amounted to a proportion varying from half to all of the reported income of thirty-two of the families incurring charges of over \$500. Of the families reporting incomes in 1933 ranging from \$1,200 to \$2,000, 15 per cent reported medical and dental charges from \$100 to \$200, while another 8 per cent reported charges of from \$200 to \$500.

In the income group between \$2,000 and \$3,000, 19 per cent of the families incurred charges between \$100 and \$200, and 14 per cent incurred charges between \$200 and \$500.

A great variety of health insurance schemes exist in various parts of the world. These include voluntary, semi-voluntary and obligatory plans.

The general tendency in recent years has been towards the extension of obligatory health insurance schemes in areas where they already existed, and the adoption of obligatory schemes in areas where previously only voluntary or semi-voluntary schemes had existed. This tendency has been slightly checked in some areas by the financial difficulties associated with the present economic depression.

The survey reveals defects in the existing organization of medical and dental services in California. A study of different systems of health insurance reveals the existence of defects in all of them.

Perfection is unattainable. The merits and defects of existing arrangements have to be compared carefully with the merits and defects of alternative arrangements.

## PSYCHOTHERAPY\*

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Discussion by H. Douglas Eaton, Los Angeles; Clifford W. Mack, M. D., Livermore; Thomas G. Inman, M. D., San Francisco.

IT is frequently asserted that psychotherapy is the oldest form of medical treatment. The inference might be drawn therefrom that in such an old and well-established practice, a review of its various techniques at the present time might be superfluous. However, there has arisen a situation in the general field of medicine that makes a consideration of psychotherapy peculiarly opportune.

### THE SCIENTIFIC METHOD OF APPROACH IN MEDICINE

With the advent of the scientific method, and with its application to the field of medicine, there has developed a point of view that emphasizes, almost to the exclusion of others, the objective attitude toward the problems encountered. The essential character of science is not in the nature of the facts with which it deals, but in the method of attack which it employs. This method consists in the well known formula of, first, the observation of phenomena; second, the orderly arrangement and classification of the facts which have been observed; and, third, the finding of laws which will serve to explain those facts, and enable

\* From the Department of Neuropsychiatry, University of Stanford School of Medicine.

Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

\* Editor's Note.—Income figures given are net. The Final Report, based on a larger number of replies, may show variations from figures here printed.

us to predict and control the occurrence of future phenomena of the same order.

This method as applied to medicine has radically altered the entire discipline. The study of physiology has developed from a relatively simple investigation of the functions of the living organism into an elaborate search for the ultimate in living processes as expressed in the function of detachable parts. This has led to the erection of bigger and better laboratories, in which may be studied the finer details by physical, physicochemical, and biochemical means. Pathology has become concerned not only with the microscopical study of diseased cells, but it goes further into the ultra-microscopic interpretation of intracellular relationships. Bacteriology is no longer content to identify certain organisms, but must identify the subtypes and their variations. The pursuit of these and similar studies has had the tendency to emphasize the importance of the various phenomena to the exclusion of a consideration of the patient. While these studies have contributed immeasurably to the understanding of disease and disease processes, they have not added much to our understanding of the total patient. We have attained a place in the practice of medicine where, despite the possession of more exact methods of diagnosis and more complete knowledge of the nature of disease than ever before, we find physicians asserting that they are unable to treat from 40 to 50 per cent of their patients because they are "psychoneurotics," or admitting that, in their treatment, they are not giving the patient what he thinks he is getting or what he is paying for.

#### PSYCHIATRY'S CONTRIBUTION

If this be true—and statements made by professors of medicine throughout the country in a recent survey indicate that it is true—what has psychiatry to contribute at the present time for the relief of this situation? In the first place, it should contribute a point of view. Sound psychotherapy presupposes a knowledge of what constitutes normal behavior. As indicated by the prevailing trends in psychiatric education, this knowledge is embraced in the subject-matter designated by various names, but most commonly as psychobiology, a term introduced by Adolf Meyer. "Psychobiology," says Doctor Meyer,<sup>1</sup> "starts not from a 'mind' and a 'body,' but from the fact that we deal with persons as biologically organized units and groups, behaving in more or less definable situations. It studies chiefly others and ourselves, very much as we study others. It occupies itself with a 'body in action,' as far as we are able to denote behavior and function of that entity best described by the terms 'he' or 'she.' We are aware of a contrast between the activity of detached or detachable organs, such as the heart or the stomach or the brain, and the activity of these same parts when functioning as part of the 'he' or 'she,' or 'you' or 'I,' that is, units with subject organization and personality function. It is behavior, overt and internal, or implicit, as far as the organisms or person works as the 'he' or 'she' that concerns us. What we study as behavior naturally goes far beyond what we can read off

from the dead body; we have to deal with the live organism in action, as behavior or *ergasia* in the process of life situations or life developments. There need be neither a neurological dilemma nor a philosophical one. There is a natural place for a psychobiology treating all the facts constituting man's behavior as a person—without a separation of mind and body, but as a biologically integrated organism in his natural attitude reaction or action, the material of a person's life record. It cultivates the habit of singling out what plays a vital rôle, in terms of specific experiments of nature, the conditions under which it occurs, the factors that enter into it when working, their results and their modifiability; in other words, a genetic-dynamic distributive analysis and synthesis."

#### PSYCHOPATHOLOGY

Such a concept of behavior furnishes a sound foundation upon which to build an understanding of the deviations of behavior which are found in the various categories of mental disease. This understanding is considered under the general heading of "psychopathology." This "science," which attempts to explain the problems of mental disorder by psychological principles and laws, has had a remarkable advancement through the work of various schools. Developing upon the background provided by Mesmer with his magnetizers, Braid with his hypnotisms, Charcot with his suggestion and hypnosis, Dubois with his persuasion, and followed by Freud and the psycho-analytic school, there has arisen a concept of mental disease and the underlying mechanisms that has altered all subsequent procedures. Many controversial points have arisen and many are still unsettled. While there has not yet developed an exact science in this field, much has been done that is serviceable in the field of psychotherapy.

Psychotherapy may be broadly defined as an effort to influence in the right direction the attitude of the patient—to influence his attitude toward himself, toward his mental and physical processes, and toward his environment. It is an effort to teach him to understand himself, his illness, and the cause or causes of his illness, whether this cause or these causes lie in his body, in his environment, or in the superficial or deeper layers of his mental life. The method or methods by which this is undertaken vary considerably. As expressed by Thom,<sup>2</sup> the nature of the therapy may be conditioned by (1) the personality make-up of the patient; (2) the nature of the symptoms; (3) conditions under which the symptoms are acquired; (4) the purpose they solve; (5) whether the precipitating causes continue to operate; and (6) the method in which the therapist has the most confidence.

#### PROCEDURE IN THE TREATMENT OF PSYCHONEUROSES

A method of procedure in the treatment of the psychoneuroses as advocated by Strecker and Ebaugh<sup>3</sup> may be stated as follows:

1. *Establishment of Rapport Between the Physician and Patient.*—The methods followed in

establishing that feeling of respect and confidence in the physician, which must prevail if the patient is to proceed successfully in his treatment, vary greatly. Shiny instruments and long, ambiguous words have played their respective parts. An effective method, however, and one that observes the dictates of sound medicine, is a careful program of investigation instituted at the first interview. A complete history should be a history of the patient as well as of his symptoms. A careful physical examination should follow, with recourse to those instruments of precision such as the x-ray and electrocardiograph which are specifically indicated, to complete your investigation and not to impress the patient. The doubt of the patient, who has been too exhaustively examined, is equaled only by the doubt of the skilled technician who knows the limitations of his instrument; and it bears no relationship to the confidence of the physician who blindly orders another x-ray, or basal metabolism, or blood chemistry, hoping thereby to convince the patient of the absence of a proper foundation for his symptoms. A mental examination should include not only the evaluation of his intellectual capacity, but also a consideration of his emotional responses.

2. *Aeration or Ventilation*.—This may be carried out by means of direct interviews, by means of discovering and probing for such material from outside sources, by hypnosis, or by any other method. The important thing is that the patient is given an opportunity to discharge and bring out in the open all of those experiences which have been causing him serious concern, either consciously or unconsciously.

3. *Desensitization*.—This is the procedure wherein the patient is required to face frankly the traumatic and unpleasant experiences of his past. It is brought about, in the first place, by causing the patient to discuss, at frequently repeated intervals, the material of conflict elicited. These interviews are repeated until the patient can review these experiences without excessive emotional concern. Normal emotional response is to be expected, however, and it is not desirable nor necessary to expect a complete loss of emotivity in connection with the events that should normally cause concern. It is the excessive concern that is pathologic and requires to be relieved.

The term "desensitization" is also applied to the procedure followed in relieving fear or other manifestations of symptoms in definite situations. The patient is required to face the situation repeatedly until he no longer manifests the symptoms in that situation, or until he is able to tolerate or ignore the symptoms if they do occur. It is necessary, of course, to encourage and reassure these patients repeatedly while this procedure is being carried out.

4. *Reeducation*.—This accompanies the foregoing procedures. It is essentially the development of clear insight on the part of the patient into the mechanism of the illness, the establishment of new habits of response (as in desensitization), and the formulation by him of an adequate industrial, social, recreational, and otherwise useful program of activity to insure future stabilization.

5. *Desensitization of the Family*.—In addition to the foregoing, it is often advisable to desensitize the patient's family to his illness, and to reeducate them into new habits of response toward the patient.

6. *Remedy of Physical Factors*.—All contributing physical factors are corrected as far as possible. Measures for their correction are instituted at the earliest possible interview, and are utilized as psychotherapeutic aids.

The procedures outlined, to be carried out intelligently, require that every individual case be formulated in terms of its causative factors in such a way that the factors that can be modified are emphasized, and become the center of attention. Factors which cannot be altered are recognized as such, and the patient is trained to tolerate them.

The development of child guidance has introduced many new procedures, valuable alike to the psychiatrist and to the pediatrician. It has emphasized beyond anything else the importance of case studies in personality and psychiatric problems. It has effectively liberalized the social point of view of psychiatry.

A matter of great importance in the consideration of psychotherapy, as it concerns the frankly psychotic patient, is that it begins with the first professional contact with him. Highly trained personnel are greatly handicapped, and the benefit of elaborate equipment is almost nullified, if the patient encounters only difficulty and disgrace in his efforts to secure such services. As long as a legal and disciplinary attitude prevails in the procedures through which a patient is admitted to a hospital for the treatment of a mental disorder, therapy directed toward that patient's recovery will be seriously handicapped. It is of the greatest importance that the work of revising the laws governing the admission of patients into the state hospitals be carried on as the first step in a program for adequate psychotherapy in those institutions.<sup>4</sup>

Stanford University School of Medicine.

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#### DISCUSSION

H. DOUGLAS EATON, M. D. (1136 West Sixth Street, Los Angeles).—The need for a scientific type of psychotherapy in this country, and especially in our own state of California, is evidenced by the number of cultists who surround us. Christian Science, Unity, New Thought—all represent narrow attempts to fill a definite need, and their existence is a challenge to the medical profession. As Doctor Johnson has pointed out, the percentage of functional disorders, a group peculiarly susceptible to psychotherapy and a group

we are all called upon to treat, represents, in a conservative estimate, 50 or 60 per cent of all our patients. In treating these cases, many of us either entirely ignore the value of psychotherapy or utilize it blindly and unintelligently.

Doctor Johnson is to be congratulated on his clear exposition of psychotherapeutic aims and methods. A careful study of Doctor Johnson's paper will be of value to us all, wherever our special interest in medicine may be, and I find myself even more thoroughly in accord with Doctor Johnson's views after a study of his paper than I was when I heard him read it.

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CLIFFORD W. MACK, M.D. (Livermore Sanitarium, Livermore).—The treatment of mental and functional nervous diseases was for a long time in medical practice confined entirely to the somatic approach. Doctor Johnson has given us a very sane and clear-cut discussion of the treatment of these illnesses by psychotherapy. In this analysis he does not neglect the physical side, but at the same time he shows that the mental symptoms should be attacked by study of the psychic mechanism. We have long since passed the time when the mental and nervous patient is treated solely by correcting the physical abnormalities by surgery, or only on the basis of some reflex disturbance.

One of the most difficult tasks is to convince the family and friends that the essential features of the illness are in the realm of the patient's psychic or emotional life, and that they are not caused by some bodily disease. The patient even may grasp this idea much more readily than members of the family. I fully agree with Doctor Johnson as to the necessity of the reeducation of the family as well as the patient. I have often seen the work of many weeks destroyed in a short interview with the patient by some member of the family who wished to practice his or her own type of psychotherapy, or present some new theory about the illness.

There is only one point which I wish to add, and that is to call attention to the importance of suggestion as well as psycho-analysis. It may properly be argued that suggestion is only symptomatic treatment, but in no field of medicine can we neglect the value and usefulness of something that will alleviate or nullify troublesome symptoms. Doctor Johnson's exposition of the subject is of very valuable assistance to all of us engaged in treatment of nervous and mental patients.

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THOMAS G. INMAN, M.D. (2000 Van Ness Avenue, San Francisco).—This article by Doctor Johnson may be taken somewhat in the nature of a declaration of principles signaling, as it does, his entrance into the field of neuropsychiatry in California. And these principles prove to be quite sound, when gauged by modern conceptions of mental disorders.

As he has intimated, rule-o'-thumb methods are insufficient in themselves, and no hard-and-fast rule can be laid down which will be applicable to each individual patient. Yet, method is necessary, and every physician doing this kind of work must have a definite plan which he uses in his search for the causes of the disorder at hand.

Doctor Johnson has outlined very closely the aims of such an investigation, as well as the direction which treatment must take. His broad views inspire confidence, and lead to the hope that his work here may bring about a more complete understanding of this, as yet, obscure subject.

The closing comments upon the method of commitment of the insane in California voices the opinion of everyone interested solely in the personal welfare of these unfortunate patients. The primitive methods now in force seriously interfere with the early institution of treatment, and undoubtedly do much to prolong the period of hospitalization.

## COMPULSORY HEALTH INSURANCE\*†

By FREDERICK L. HOFFMAN, LL.D.  
Philadelphia, Pa.

XI

SOCIALIZED medicine is reviewed in the *Literary Digest* of December 29, 1934, in its annual review of progress made during the year in science and engineering. After an enumeration of outstanding discussions in the field of medicine, it is said:

"Socialized medicine," or the placing of physicians on government payrolls, and "health insurance," or provisions of medical treatment for the payment of small, regular, voluntary fees, were leading plans proposed. Both were bitterly opposed by officials of the American Medical Association, but health insurance was advocated by increasing numbers of physicians, dentists, nurses, and social agencies; by city, county, and state medical societies, and by the American Hospital Association, and the American College of Surgeons.

In this statement, however, the compulsory feature of the system is not emphasized, and that goes to the root of a very disturbing situation. It is seriously to be questioned whether the medical profession at large is more than vaguely conscious of what is actually implied in the various proposals. And unless it is aroused out of its apathy it may realize when it is too late that its professional independence has been sacrificed for a mediocre amount of economic security.

### MAJOR PROPONENTS OF COMPULSORY HEALTH INSURANCE

The propaganda for compulsory health insurance is largely in the hands of and within the control of nonmedical men supported, in part if not wholly, by some of the great foundations more or less international in character and purpose. The outpourings of briefs and reports reveal no thorough grasp of the proper medical considerations, but rather the academic viewpoint of the green table and easy chair philosophy. It is supported by pleas for the poor or underpaid workers whose medical needs are said to be badly neglected. It insists that the medical care of the lower-wage group should be raised to the very best that can be provided, although the richest nation of the earth could not meet the expenses which would call into being a huge administrative apparatus largely of a nonmedical nature. The British health insurance committee makes the bold assertion that this is an "Act to provide against loss of health," but no agency has come into existence in the twenty-one years of its life to provide in an effective manner against the onset of disease. It may be safely asserted that the health of the British

\* One of a series of articles on compulsory sickness insurance written for CALIFORNIA AND WESTERN MEDICINE by the well-known consulting statistician, Frederick L. Hoffman, LL.D. Articles in this series were printed in issues as follows: I, in April, 1934, page 245; II, in May, page 361; III, in June, page 411; IV, in July, page 33; V, in August, page 114; VI, in September, page 177; VII, in October, page 262; VIII, in November, page 323; IX, in December, page 398; X, in February, 1935, page 108.

† Note—As stated in the editorial masthead, "Authors are responsible for all statements, conclusions and methods of presenting their subjects" in CALIFORNIA AND WESTERN MEDICINE. See also editorial comment in this issue, page 190.

worker, or of the insured members of his family, is not much better today than it was before the Insurance Act came into being.

#### HEALTH INSURANCE VERSUS SICKNESS INSURANCE

For the insurance of health is a totally different matter from insurance against loss of health through sickness, demanding chiefly medical treatment or more or less successful curative measures. The Act provides compensation for loss of employment due to ill health, but does not go to the root of a radical change in housing and living habits, which are possible factors responsible for widespread physical impairments. Through other agencies, it is true, every government the world over aims at an improvement of environment, as well as of the living habits, of its wage-earners to promote health and long life; but these agencies are not intelligently correlated to proper health insurance, being rather in the nature of relief agencies concerned with the economic consequences of sickness.

#### ROOT OF MOST ILLNESS

A careful review of the annual reports of health officers of England and Wales, Scotland and Northern Ireland is not suggestive of the fact that national health insurance forms an integral part of the public health organization. The root of most of the illness lies in the effect of housing and nutritional, as well as industrial, conditions inimical to good health and long life. In other words, the prevention of disease is still in a very backward condition, while vast amounts of money are being spent on the cure of disease, mostly in the nature of minor ailments. This is clearly shown in the last report of the chief medical officer of the British Ministry of Health (1933), who gives a table showing the proportion of cases of certain diseases to the total cases treated by insurance practitioners in 1933, which is supposed to be a representative sample of the entire experience. The table shows that out of 125,646 cases treated, 29,698, or 23 per cent, were for bronchitis, tonsillitis, nasal catarrh, colds, etc. The next most important item was influenza, represented by 14,905 cases, or 11.9 per cent. The third factor of outstanding importance were diseases of the digestive system, with 13,915 cases, or 11.1 per cent. These three groups, therefore, represented 46.6 per cent of the total.

Of the remainder, lumbago and rheumatism came first, with 11,329 cases, or 9 per cent of the whole; followed by injuries and accidents with 10,809 cases, or 8.6 per cent, and abscess, boils, and other septic conditions with 8,803 cases, or 7 per cent. Thus, these six groups combined, mostly of a minor nature and involving heavy expenditure on the part of the insured, represented 71.2 per cent of the total cases treated.

With regard to chronic diseases, tuberculosis, all forms, was represented by 905 cases, or 7 per cent of the total; organic heart disease, with 1,589 cases, or 1.3 per cent; anemia with 1,578 cases, or 1.3 per cent; diseases of the nervous system,

with 7,046 cases, or 5.6 per cent; and skin diseases, with 6,112 cases, or 4.9 per cent.

Of the more serious and often prolonged respiratory diseases, pneumonia accounted for 1,699 cases, or 1.4 per cent of the total. Diseases of the genito-urinary system numbered 3,854 cases, or 3.1 per cent; while malignant disease or cancer numbered 221, or 0.2 per cent.

#### LIMITATIONS OF NATIONAL HEALTH INSURANCE

Hence it is clear that most of the money in national health insurance is spent upon trivial ailments, many of which are merely alleged conditions to secure relief by unemployment. Hospital care and surgical treatment are not provided for by national health insurance, but if provided would easily double the cost of the system.

Comparing the death rates for some of the more serious afflictions, including chronic diseases, the record for the last ten years is as follows: Erysipelas increased from 1.8 per 100,000 to 2.5; encephalitis lethargica from 0.9 to 2.1; cerebrospinal fever from 0.9 to 3.0; cancer from 122.9 to 151; nonmalignant tumors from 2.7 to 3.9; chronic rheumatism and osteo-arthritis from 5.9 to 7.9; diabetes from 11.9 to 15.2; diseases of the thyroid and parathyroid glands from 2.7 to 4.5; cerebral thrombosis from 6.2 to 11.6; paralysis agitans from 1.9 to 3.5; disseminated sclerosis from 1.9 to 2.2; aortic valve disease from 7.8 to 8.4; mitral valve disease from 24.6 to 25.2; myocardial degeneration from 40.4 to 117.4; diseases of the coronary arteries and angina pectoris from 3.8 to 19.1; disordered action of heart from 1.6 to 6.5; aneurysm from 2.7 to 3.2; lobar pneumonia from 24.1 to 24.9; ulcer of the stomach or duodenum from 6.8 to 9.9; appendicitis from 7.2 to 7.5; hernia and intestinal obstruction from 11.1 to 12; biliary calculi from 2.6 to 3; diseases of the gall-bladder and ducts from 1.7 to 2.8; diseases of the pancreas from 0.6 to 1.3; nephritis, all forms, from 33.2 to 40.6; other diseases of the kidney and annexa from 1.6 to 2.6; calculi of the urinary passages from 0.8 to 1.1; diseases of the prostate from 11.6 to 22.4; diseases of the skin and cellular tissue from 4.5 to 4.9; diseases of the bones from 2 to 2.4.

On the other hand, of course, many diseases have diminished in incidence, but I have for the present considered only those which I am claiming are not receiving adequate and proper attention under national health insurance. The foregoing figures have all been abstracted from the annual report of the Registrar General for 1932, covering the period of 1922-1932.

#### SOME BRITISH OPINIONS ON THE LIMITATIONS OF HEALTH INSURANCE

The present limitations of national insurance in Great Britain are recognized by every authority on the subject, and countless reports voice the opinion of its inadequacy in unmistakable terms. For example, at a recent meeting of the Nottingham Insurance Committee, the chairman, in his report, observes:

"The work in insurance committees is to deal with the maintenance of a healthy life of insured persons, and to provide medical attendance and other measures for such of them as fall out of health, and the extension of the medical service should, I think, be one of the first considerations. There is no need for me to dwell on the present inadequacy of the medical service, well though the majority of panel practitioners play their part. . . . I am of the opinion that it is essential in the interests of insured persons that the supplementary services, so much discussed in the past, are necessary today in order to secure a complete and adequate medical service for the insured community, and in addition thereto a system of medical treatment and attendance by panel practitioners to the dependents of insured persons, administered by and through insurance committees."

Furthermore, the chairman observes:

"I do feel, however, that eventually the National Insurance Act will of necessity have to be amended on the lines of the new Unemployment Insurance Act so as to bring boys and girls on leaving school within its scope, as the inconsistency in our two great social schemes cannot, I think, be reconciled for long." (*National Insurance Gazette*, November 15, 1934.)

In a report concerning the Medical Service Subcommittee of the London Insurance Committee, October 25, 1934, mention is made of the procedure followed in the case of a panel doctor who had failed to diagnose correctly cancer of the lung. The subcommittee said that, as a result of their consideration of the case, they found that the insured person had received proper attention, although he died from a cause not diagnosed. The subcommittee recommended concurrence with local medical committees' view that the following services were outside the scope of terms of service, and practitioners concerned might charge patients privately therefor: "(1) Enuclation operation for removal of tonsils by dissection; (2) ultra-violet rays for asthenia; (3) local treatment with Tungsten arc lamp for ringworm on neck; (4) estimation of refraction—subjective and by retinoscopy for presbyopia; (5) retinoscopy and prescribed spectacles; (6) retinoscopy and ophthalmoscopy; (7) ultra-violet rays for postherpetic neuralgia; (8) retinoscopy and prescribing glasses; (9) dilation and curettage for chronic endometritis; enlarged uterus, chronic backache, discharge and menorrhagia."

I quote also from a report of Dr. L. Llewellyn-Jones, one of the foremost authorities on national health insurance in England, who presided at the meeting of the Flintshire committees, November 8, 1934, and is stated to have said that

"He himself was sorry to see the tendency nowadays in the direction of bureaucratic policy, which he thought was a huge mistake in the administration of national health. The experience gained in the last twenty-one years of the benefits of national health insurance had shown that there was a great deal to be done before they could sit down and say they were well satisfied. The scope of medical benefit at present was a comparatively narrow one. As soon as an insured person required treatment which necessitated a consultant or the services of an expert surgeon the resources of insurance committees came to an end, and they were not in a position to arrange for that further treatment. There was nobody today who did not feel there was a gap which ought soon to be filled if they thought that the scheme was what they thought it was going to be twenty-two years ago. There was another line of advance which he would like to see. And that

was a closer connection and correlation between the insurance services and the public health services of the local authorities. There was a section of the 1911 Act which seemed to contemplate that, but it had never been put into operation. In 1924, when the Government brought in a Consolidating Act, that section was dropped. There ought to be much closer coöperation between the two bodies than existed at present. He would like to see an attempt made to bridge over the gap between the time a child left school and the time it entered the national health services. They, as insurance committees, could do a great deal in the way of impressing public opinion with the reasonableness of what they were claiming, and as regards paying more attention to matters of public health whether on the clinical or on the preventive side."

The foregoing extracts will clearly illustrate the limitations of health insurance inherent in the system, and the inadequacy of the contributions to provide for all the emergencies that may arise chiefly, however, in connection with prolonged cases of chronic illness which are not properly provided for under the present system.

#### AN ILLUMINATING SIDELIGHT ON PANEL PRACTICE

An illuminating sidelight on panel practice is contained in an article in the London *Lancet* of September 29, 1934, which bears the suggestive heading "Placebo Prescribing." Placebo, according to the medical dictionary, is "An indifferent substance, in the form of a medicine, given for the moral or suggestive effect." In other words, placebo is a pretense and a fraud. In the article referred to, the question is raised as to whether patients as a rule expect a prescription or a bottle of medicine when they consult a doctor, it being stated that the chemists' accounts for insured persons increased from a total of about \$9,046,000 in 1932 to a total of about \$9,632,000 in 1933. It is then said:

"All doctors are familiar with the patient's statement that the very first dose did him good, and it would be a foolish man who refused to repeat that mixture. There is the story of the old lady who could not do without her cough mixture, and on one occasion when she sent up for it and her doctor was out his wife put an ounce of Camp coffee in the bottle, filled it up with water, and told the messenger that the mixture has been changed. Most practitioners who dispense keep a mixture labelled "ADT": A for any, T for thing, D for what you like—to be used for people who are thought not to require medicine at all, but who would consider themselves neglected if they did not get something."

#### UNNECESSARY MEDICINE AND ITS COST

Attention is next drawn to the fact that Sir George Newman, in his annual report, raised the question of unnecessary medicine and its cost. In other words, a vast amount of prescribing serves no useful purpose, but is in the nature of a fraud upon the insured who are given a medical concoction as a matter of pretense and downright imposition. But the vast amount of trivial ailments in the doctor's practice could not result in any other procedure. As I said before, the patient is chiefly interested in a certificate for incapacity for work entitling him to a cash benefit, and as long as this is true the condition referred to is not

likely to be improved upon. The article observes that the general cost of prescribing has gone up and continues to go up. Sir George Newman states that is due to the modern tendency to prescribe expensive drugs, such as insulin and liver extract, and that inasmuch as these drugs are necessary, it becomes more than ever important that money which should be available for their cost is not frittered away in placebos. But the doctor in question has no alternative that may involve the risk of losing his clients who would transfer to a more complacent medical attendant. As said in the *Lancet* article:

"The determining factor in the doctor's view is the fear of offending his patient, thereby risking the loss not only of that patient, but possibly his family and relatives. But whilst cantankerous patients leave Dr. A., they also leave Dr. B. and Dr. C., so that what Dr. A. loses in one family he gains in another."

In a further article in the *Lancet* on the same subject, it is said, referring to Sir George Newman's report:

"You say 'the public appreciates what it has to pay for.'—As it is, panel patients have a suspicion that the panel doctor's medicines are not so good or 'so strong' as those prescribed by private doctors or by the same doctors for their private patients. A common remark is: 'I told him I didn't want any panel stuff and he gave me a bottle of really good medicine. You see they won't let them give really good medicine on the panel except when you are very ill indeed.' Whether we are wise to attempt to take away the prop that a bottle of medicine provides when we have so little else curative in our armamentarium is again another matter. It seems likely that the quack dispenser would have scope for a flourishing trade if doctors really gave medicine only when it is required. Before we manage to do without a bottle of medicine we shall probably have to invent some other symbol or idol."

#### NUMBER OF PERSONS INSURED IN GREAT BRITAIN

Several references have been made in this and previous papers to the increasing sphere of national health insurance in Great Britain by the inclusion of new categories of members, particularly the young between sixteen and eighteen years of age. According to a recent statement by Sir Hilton Young of the Ministry of Health, the numbers of persons in Great Britain who, on December 31, 1933, were insured for health and pension purposes, respectively, were approximately 18,481,000 and 18,793,000. The number of insured persons under twenty years of age on December 31, 1931, was approximately 2,500,000. Thus, to the extent that the number of insured increases, the sphere of the private practitioner is curtailed. In Germany the number of members in compulsory health insurance sick funds increased from 17,539,000 in January, 1933, to 20,163,000 in June, 1934. The experience elsewhere has been similar.

The application of the foregoing facts and information, concerning the experience of compulsory health insurance abroad, to American conditions is obvious. Unless we are ready to merge a large proportion of our doctors in a federal health insurance service, we had better consider the possible effects on the general medical practice. Of course, the agitation for compulsory health in-

surance rests, to a large extent, upon the free treatment of the poor for which compensation should be made by the State.

#### HOW CAN INDUSTRY ASSUME THE BURDEN OF NATIONAL HEALTH INSURANCE

The demand that industry shoulder a large proportion of the cost of compulsory health insurance is a preposterous imposition. Industry as it is has a hard enough time to avoid bankruptcy in view of the immense hardships of interstate competition. Its position would be infinitely worse with compulsory health insurance demanding that 50 per cent of the contributions be paid for by the employer. Nothing would suit European nations better than for us to assume such a colossal burden, to equalize still further the economic differences between this and other countries. Efficient medical practice is difficult enough as it is, and should not be burdened with an immense variety of rules and regulations and supervision and control on the part of state and federal authorities which would hinder its progress and curtail opportunities now open to all physicians engaged in private practice. Once such a bondage has become an established fact, it is extremely difficult for any country to do away with it.

#### PROPOSED BILL OF THE AMERICAN ASSOCIATION FOR SOCIAL SECURITY (EPSTEIN BILL)

Regardless of our precarious financial situation, social reformers are pressing their plans for socialized insurance with increasing vigor. An organization known as the American Association for Social Security, according to the *New York Times*, has made public its Social Security Bill<sup>†</sup> which, it is stated, will be introduced as a model measure in forty-three state legislatures now convening, and the provisions will be made the basis of a federal subsidy bill to be introduced into Congress in the near future. It is said, in the article referred to, that "the two steps combined are designed to provide a health insurance system under which the great proportion of those earning less than \$3,000 a year would receive essential medical services and part compensation for loss of income by illness."

The object of the federal bill is "the establishment of a system of health insurance which will provide protection of the population which is unable to budget individually for adequate health services or to bear the loss of income by illness. . . . Its basic aim is to equitably distribute the burden that illness involves. There is no attempt in this bill to reorganize the medical profession as such in any manner whatsoever." All this is mere meaningless verbiage, for the moment such a bill is enacted the medical profession will be drawn into it on a large scale, and will be divided into those who are on the Panel and those who are not. Compulsion for the payment of the contributions will be a most essential feature, and a heavy burden both upon the employers and the employees. In view of the reckless spending of

<sup>†</sup> For other comment concerning this bill, see *Journal of the American Medical Association*, February 2, 1935, p. 400.

federal money, the enactment of radical legislation of all sorts is by no means improbable, and such a measure may become a law unless the medical profession uses its utmost influence to protect its interests against adverse legislation.

#### BRITAIN'S FIGURES ON THE COSTS OF ITS HEALTH INSURANCE

What, in the long run, such a system may amount to in dollars and cents is best illustrated by the British experience with a record of nearly a quarter-century available. Since 1921 the total receipts from all sources, contributions, parliamentary grants and interest, have amounted to \$3,187,781,000. Of this, the amount paid by direct parliamentary grants is represented by the tidy sum of \$665,602,000. Of the total expenditure, \$420,122,000 represents the cost of administration, compared with \$140,641,000 for maternity benefits and \$755,000,000 for medical benefits. This represents the cost for England and Wales only, with an approximate population of about forty million.

At the present time the annual receipts from contributions, parliamentary grants, interest, etc., amount to about £32,000,000, or not quite \$150,000,000. That applied to the American population, with due regard to the higher standards of living and higher cost of compensation, would bring the annual cost of a system of socialized insurance to possibly a billion dollars, considering that many more benefits would be expected in this country than abroad.

#### COMPARISON OF GENERAL REVENUES OF CALIFORNIA AND MASSACHUSETTS

Since the States would have to bear a large proportion of the expense, let us consider the facts for the State of California compared with the State of Massachusetts, derived from the latest figures available from the Census Office.<sup>‡</sup> For 1932 the per capita revenue of California was \$106.85, while for Massachusetts, 1931, the corresponding figure was \$89.51. The per capita expenditures were \$113.78 for California and \$96.31 for Massachusetts. The per capita gross debt, less sinking-fund assets, was \$186.15 for California and \$101.77 for Massachusetts. The per capita gross debt, less sinking-fund assets, has increased in California from \$55.01 in 1912 to \$142.81 in 1922 and \$186.15 in 1932, and in Massachusetts from \$75.28 in 1912 to \$82.30 in 1922 and \$101.77 in 1931.

#### RECENT HEALTH AND SANITATION EXPENDITURES IN CALIFORNIA AND MASSACHUSETTS

In an estimated population of about six million for California, the amount spent on health and sanitation in 1932 was \$15,369,000. In Massachusetts, with an estimated population of about 4,500,000, the amount spent on health and sanitation in 1931 was \$22,096,000. What is to be the future of State finances under such alarming conditions? In its last analysis, the burden of tax-

ation falls most heavily upon the productive industries and the wage-earner's income. With the higher cost of living, which is inevitably in prospect, and with a substantial reduction in wages on account of health insurance or social insurance payments, the wage-earner may well pause to give approval to this fantastic scheme of reform which has little to commend it.

#### MUTUAL HEALTH SERVICE OF WAYNE COUNTY, MICHIGAN

There is a way out of the difficulty which demands attention. In Detroit, Wayne County, Michigan, the county medical society has inaugurated a voluntary plan of medical service, with every assurance of success. What is possible in Detroit is possible in every other community in the United States, and the facts of the situation should be carefully studied by every local medical society.

In brief, the Wayne County Medical Society provides for a coordinating center, with a social service set-up, for those cases which require assistance in obtaining and paying for complete medical service, including hospitalization and medical, dental, nursing, and pharmaceutical service. This is more than the European plans provide at the present time, or are ever likely to provide. All the members of the society become the active staff caring for patients, and all forms of medical care, including consultation, x-ray, and laboratory procedures, are to be performed in the office or laboratory of the physician or at the hospital where he takes the patient. The plan includes hospitalization, all the major hospitals of Detroit, except one, cooperating.

Industrial concerns are cooperating by making the service known to their employees, while factories and shops also are cooperating by giving information and in the collection of accounts. The plan has been welcomed by every employer approached.

If the patient has no personal physician, he may choose one, and an identification card is given him to be presented to the doctor of his choice. If several physicians and a hospital cooperate in the care of a case, the bills or fees are combined into one bill, the physicians and hospital, not the Bureau, setting the fee. The payments when received are then distributed to each cooperating physician, hospital, dentist, or nurse. By this method the recognized patient-physician relationship is preserved. It is explained that this plan does not affect compensation cases. The patient has free choice of hospitals, specialists, and laboratories exactly as in private practice.

It is furthermore said, "The most important feature of this plan is that it places complete medical and hospital services within the reach of every worthy patient, and provides an easy payment for the settlement of medical bills."

The following facts are of particular importance. Wayne County has about 7,000 medical units, doctors, dentists, nurses, hospitals, and pharmacists, and approximately 1,100 industrial concerns employing more than one hundred workmen each. The cooperation of all these is neces-

<sup>‡</sup> Including the State and all local administrative areas.

sary if the plan is to be successful. The Detroit plan is as yet in its initial stage, and "the work of contacting employers has been sandwiched in between many other duties so that, to date, only thirteen industrial concerns have been approached. The total employment at the plants contacted is approximately 65,000 men. In each case the industrialist stated he would gladly tell his workers; he would also verify employment, wages, etc., in the investigation of the patient. In every case the manufacturer is willing to assist us in making collections. This is not surprising, because the plan offers many distinct advantages to the employer, such as (1) certainty that the employee will be well cared for; (2) relief from a portion of the necessity for employee loans; (3) greater efficiency through better health of employees; (4) one centralized bureau with which to cooperate; and (5) no dues, fees or payments of any kind before actual service has been received."

#### HOW THE WAYNE COUNTY PLAN HAS WORKED OUT IN PRACTICE

The Bureau began to function in February, 1934, and up to August 18, 1934, had handled 1,085 individual cases. According to *The Medical News* of Detroit for October, 1934, "the number of employees involved in the industries already actively cooperating with the plan is 229,980." In brief, the Detroit plan provides complete medical and hospital service within the reach of every worthy patient by means of an easy-payment plan for the settlement of medical service bills. Physicians and hospitals, not the Bureau, set the fee. Thus, the self-respect of the patient is preserved regardless of what the situation may be. Nothing more admirable has been evolved in all the numerous plans for socialized medicine on a compulsory or voluntary basis. As observed in a report on the bill in *The Journal of the American Medical Association* for September 8, 1934: "The plan should increase the health and happiness of Detroit and Wayne County citizens, as it provides a method whereby people can procure needed medical services. It should remove a large proportion of the financial reasons for delaying medical service. The consolidation of medical and hospital bills, with the arrangement of definite terms at the time the service is rendered, should result, with the cooperation of the employer and all concerned, in an increased ratio of collections."

And finally: "Physicians send their bills computed at their usual fees for these patients to Bureau headquarters, giving certain details of their charges. The physician does not make collection of these charges—the central bureau makes arrangements for collections and has the cooperation of the employer. To defray the cost of operating the Bureau, 10 per cent of sums actually collected is retained by the Bureau."

As regards those unable to pay for medical services at the time such service is rendered, it is said that in such cases the patients are always returned to their family physician with a plan of deferred payments, and that "the majority of these patients sought charity because they did not have

sufficient cash in reserve to meet the full fees incident to a medical emergency. Their prime need was credit, not free medical care."

#### ADVANTAGES OF THE WAYNE COUNTY PLAN

Here, then, is a plan worthy of the most careful consideration on the part of those who sincerely believe that some form of medical reorganization is necessary to provide for the needs of poorly paid workers unable to meet their medical bills. The Detroit system eliminates entirely the need of compulsion and state interference, and avoids the extremely costly advisory bodies which come into existence in a system of compulsory health insurance. It preserves the independence and integrity of the medical profession and avoids class distinction both on the part of the beneficiaries of the system and the doctors. It eliminates an enormous amount of political discussion incident to compulsory administration, and leaves the doctor time for the scientific study of medicine. It should go far to improve the general health situation and to lower the death rate from preventive or curable diseases.

#### DEATH RATE IN BRITAIN AND THE UNITED STATES

With reference to the death rate, it may be pointed out that the rate for England and Wales in 1933 was 12.3 per one thousand, compared or contrasted with a rate of 10.7 for the United States during the same year. In 1912, when the British system was established, the death rate for England and Wales was 13.4 per one thousand, while that for the United States registration area for the same year was 13.9. In tabular form the comparative results are as follows:

COMPARATIVE DEATH RATES PER ONE THOUSAND, 1912 AND 1933		
	England and Wales	U. S. Registration Area
1912 .....	13.4	13.9
1933 .....	12.3	10.7

Hence it is shown that while there was a decrease of 1.1 per one thousand in the death rate for England and Wales, the corresponding decrease in this country was 3.2. The first was achieved with health insurance and the second without it. The boasted benefits to the British population are largely a matter of conjecture, for in its last analysis the death rate is the court of last appeal in a discussion of this kind. The questions involved may be presented to advantage in a somewhat more convincing method of details.

Considering twenty-eight leading causes of death in the United States and England and Wales for the year 1933, it appears that eighteen causes show a lower death rate in this country, while ten show a higher rate. The combined mortality from those diseases showing a lower rate in this country was 747.5 for 100,000 for England and Wales, and 507.4 for this country; while for the ten causes with a higher rate in this country the combined rate was 211.9 per 100,000 for England and Wales, and 298.6 in this country. The diseases showing a lower rate for this country are given in Table 1, with the rates per 100,000 population.

TABLE 1.—Diseases Less Common in the United States  
(Rate per 100,000)

	U. S. Regis- tration Area	England and Wales
Influenza .....	26.4	56.7
Erysipelas .....	1.6	3.0
Tuberculosis (all forms).....	59.5	82.4
Cancer and other malignant tumors..	102.2	152.6
Acute rheumatic fever.....	2.0	3.2
Chronic rheumatism, osteo-arthritis	1.3	8.0
Diseases of the thyroid and para- thyroid glands .....	3.3	4.6
Anemia .....	3.4	6.7
Diseases of the heart and circula- tory system .....	249.8	330.4
Chronic bronchitis.....	1.5	18.4
Bronchopneumonia .....	29.3	40.8
Asthma .....	1.5	4.4
Pleurisy .....	2.1	2.3
Diseases of the buccal cavity, etc.....	4.5	4.9
Ulcer of the stomach and duodenum	6.0	10.2
Hernia, intestinal obstruction .....	10.0	11.8
Diseases of the skin and cellular tissue .....	1.7	4.9
Diseases of the bones and organs of locomotion .....	1.3	2.2

The diseases showing a higher rate in this country are given in Table 2.

TABLE 2.—Diseases More Common in the United States  
(Rate per 100,000)

	U. S. Regis- tration Area	England and Wales
Typhoid fever .....	3.5	0.5
Syphilis .....	8.8	3.3
Diabetes .....	21.3	15.6
Leukemia and pseudoleukemia.....	3.6	3.2
Alcoholism .....	2.6	0.2
Diseases of the nervous system.....	104.2	96.8
Lobar pneumonia .....	36.4	24.4
Appendicitis .....	14.1	7.6
Cirrhosis of the liver.....	7.4	3.1
Diseases of the genito-urinary system	96.7	57.2

The contrast in local disease frequency is highly instructive. Obviously the diseases which should benefit most under a health insurance system are higher than they are in this country, with the important exception of syphilis, diabetes, lobar pneumonia, appendicitis, cirrhosis of the liver, and diseases of the genito-urinary system. Syphilis and genito-urinary diseases, chiefly chronic nephritis, are affected by race, being much more common among the negro population. If it were not for the negro element, our general and specific death rates would be decidedly more favorable in contrast with the returns for England and Wales. Highly significant are the high rates for rheumatic fever and chronic rheumatism in that these two diseases receive major attention under health insurance. Hence the conclusion that our health system without health insurance is decidedly more favorable than that of England and Wales, and that indications for a further decrease in specific death rates are more pronounced in this country than in England.

In conclusion, I quote an interesting paragraph from a treatise on German medicine by the Hoeber Press, recently published. It is one of a series of volumes on the history of medicine and written by one who evidently speaks with authority on the questions under consideration. Regarding health insurance, he remarks: "The financial status of the medical profession became much weakened in

1883 by the introduction of the compulsory public sickness insurance (Krankenkasse). The physician's salary for the immense amount of work required under this system is most inadequate; the insurance covers a large part of the population: workingmen, clerks and their families, and so on. At first the insured persons did not have the privilege of choosing their physicians, but as a result of the efforts exerted by the 'Verbände der Aerzte Deutschlands,' this has been changed, and now the patients do have the privilege of selecting their physicians." (*Journal of the American Medical Association*, October 27, 1934, page 1330.)

#### IN CONCLUSION

With this statement I leave the subject which I have tried to present impartially in the light of such evidence available to me, both from German and British sources. To my mind, there can be no other conclusion than that the adoption of compulsory health insurance is not to the interest of the American medical profession, while it is equally opposed to the best interests of the public. I have given much of my time during the last thirty years to a patient study of the facts, and my earlier convictions as regards the inexpediency of compulsory health insurance remain unchanged. I trust that what I have written will be of benefit to the American medical profession and arouse organized opposition to any and every effort to force such an uncalled for system upon the American public, who, in its last analysis, have to bear the burdens of increased taxation and decreased economic efficiency in international trade competition.

## THE LURE OF MEDICAL HISTORY\*

### THE INFLUENCE OF CLAUDE BERNARD ON MEDICINE IN THE UNITED STATES AND ENGLAND†

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II‡

#### BERNARD'S INFLUENCE ON THE TEACHING OF PHYSIOLOGY IN AMERICAN MEDICAL SCHOOLS

Many of the young American physicians who listened to Bernard's lectures afterwards became professors in medical schools in the United States, but hardly one carried on research along physiological lines. Dr. Henry H. Donaldson of the Wistar Institute of Anatomy gives us a picture of conditions in the 1880's which is particularly interesting because he had his physiology under Dalton: "In the eighties the teaching of medicine,

\* A Twenty-Five Years ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany Department of CALIFORNIA AND WESTERN MEDICINE and its page number will be found on the front cover index.

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‡ Part I of this article was printed in February issue, CALIFORNIA AND WESTERN MEDICINE, page 111.

with which physiology was mainly associated, was poorly developed. I entered the College of Physicians and Surgeons in New York in 1880. It was then a proprietary school. You paid your fee and were enrolled. You could get your degree in two years by attending endless lectures and taking quizzes with a preceptor. There was a dissecting room, but no laboratories. Dalton held the chair of physiology. He was lucid in his presentation, largely based on French work, for he had been trained in Paris. An exposed heart is the only demonstration I recall." It would appear that even if Dalton did at first attempt to illustrate his lectures with experiments "on living or recently killed animals," this ideal was not being put into practice in the later years of his career as a teacher.

The truth is that for years any one with an M. D. degree was considered qualified to teach any subject in the medical curriculum. An excellent example is shown in the case of Stanford Emerson Chaillé (1830-1911). Descended from a Huguenot refugee and born in Mississippi, he took his A. B. at Harvard in 1851, and his M. D. at the University of Louisiana in 1853. After another year at Harvard, getting his M. A., he embarked on a three-year European tour. He attended Bernard's lectures while in Paris. Upon his return to Louisiana he was for nine years a demonstrator in anatomy, serving, meanwhile, as surgeon in the Confederate Army during the Civil War; for a year he was lecturer in obstetrics, then became professor of physiology and pathological anatomy; for a short time he switched to the professorship of obstetrics, but later returned to the professorship of physiology and pathological anatomy.

It was not until very late in the nineteenth century that American medical schools became centers for investigation. In fact, the American Physiological Society, whose meetings were designed for the very purpose of discussing original investigation, was not formed until 1887. This society was started at the suggestion of Weir Mitchell and he was elected its first president. One is strongly reminded of Bernard's relations to the Société de Biologie of Paris, which he was instrumental in founding in 1848, and of which he later became perpetual president. Among the most active members of the American society was Henry Pickering Bowditch (1840-1911), professor of physiology at Harvard. Bowditch's father had been one of Louis' most enthusiastic followers and had spent the years of 1832-1834 under Louis' guidance at the hospital of La Pitié. Although it is stated that the son "came into relations with Claude Bernard in Paris," he actually did his work abroad in Ludwig's laboratory in Leipsic.

One must admit that almost without exception these young American physicians who continued their medical studies in Paris were really interested in the more practical aspects of medicine. In England this was not the case. There were, of course, many English physicians who listened

to Bernard and returned home to practice. They, too, could follow Bernard's more recent discoveries in their own medical journals, and could even read notes on complete series of lectures, such as those of Dr. Benjamin Ball published in the *London Medical Times and Gazette*, 1860-1861; which, by the way, were translated back into French for use as part of the text of the volume on Operative Physiology published after Bernard's death. But, in contrast to the state of affairs in the United States, the teaching of physiology in the great educational centers of England where the science was being advanced bears the stamp of Bernard's direct influence.

#### THE TEACHING OF PHYSIOLOGY IN BRITAIN'S MEDICAL SCHOOLS

When William Sharpey (1802-1880) came from Edinburgh to occupy the newly instituted chair of General Anatomy and Physiology at University College, London, in 1836, he had had training chiefly in microscopic anatomy. Sir Edward Sharpey-Schafer makes the following statement regarding Sharpey's teaching: "It is true that his lectures were largely anatomical, that he carried out no physiological researches, that he performed no experiments on muscle and nerve other than those which had been performed by Galvani half a century earlier, that he never possessed a kymograph (the working of which he would illustrate to his class by revolving on the lecture table what Michael Foster called his 'dear old hat'), but he had a remarkable grasp of the problems of physiology, and a singular power of imparting his conclusions to his audience."

Sharpey, wishing to do more to encourage the science of physiology in England, induced a young physician, George Harley (1829-1896), to start in 1855 a class in Practical Physiology at University College. Why should he have chosen this particular young man? Like Sharpey, Harley had taken his M. D. at Edinburgh (1850), but during two years spent in Paris he had received special training in physiology under Magendie and Bernard. It was to this young man that Bernard referred when he spoke of "M. Harley (*sic*), who at one time took my course." Under Bernard's direction Harley worked on the effect of injecting irritating substances into the portal vein. This was the period of intensive work in Bernard's laboratory on the glycogenic function of the liver. The impetus which Harley received is seen in his two treatises on the liver, the first written in 1853, the second twenty years later.

About the time that Harley was introducing Bernard to University College, London, Frederick William Pavy (1829-1911), was doing the same at Guy's Hospital. Pavy, after taking his M. B. with honors at the University of London in 1852, followed the custom and left for further study in Paris. There were so many English medical students in Paris in the fifties that they had organized the English Medical Society of Paris, which met weekly in rooms near the Luxembourg to read papers and report on interesting cases.

Both Harley and Pavy were officers in this society. Pavy's experiments under Bernard's direction on the mechanism of the destruction of sugar in the organism were characterized by the master in one of his lectures at the Collège de France as "très intéressantes." Pavy was so profoundly influenced by Bernard that he, too, devoted his life to the subject so intensively worked on by the master, viz., diabetes, and was even said to imitate him in the manner of his lectures. Two of his books are "Researches on the Nature and Treatment of Diabetes" (1862) and "The Physiology of the Carbohydrates, Their Application as Food and Relation to Diabetes" (1894). Pavy's later experimental work seems to have been largely an attempt to improve on Bernard's method of sugar estimation. He disagreed with Bernard on the subject of glycogenesis, for he did not get the same results as Bernard had done in determining the relative amounts of sugar in the blood of the portal and hepatic veins. One of the few times Bernard attacked an adversary with sarcasm was when he refuted "the ideas held particularly by M. Pavy, an English physiologist, who began his experiments on animal sugar in my very laboratory at the Collège de France," that the appearance of sugar in the liver is a postmortem phenomenon. "M. Pavy's theory is a reflection of the old vitalistic doctrines and is at the same time obscure and inexact. . . . M. Pavy would thus be led to consider the diabetic patient as a walking corpse, a conception which is certainly bizarre!"

Harley did not long retain his lectureship in Practical Physiology at University College; he was soon followed by Michael Foster, a pupil of Sharpey, who had taken his M. D. at the University of London in 1859. Foster, although he, too, had followed the custom and spent a year in Paris, did not attend Bernard's courses; nevertheless, it is claimed that the greatest influences in Foster's life were Sharpey, Bernard, and Huxley. The greatness of his esteem for the French physiologist is expressed in the dedication of his well-known biography of Bernard: "To the physiologists of France, both to those who had the happiness to know Claude Bernard in the flesh, and to those who, like myself, never saw his face, this little sketch is dedicated in the hope that as he has been to me a father in our common science, so I may be allowed to look upon them as brethren."

When Foster left London to accept the chair of Physiology at Cambridge, a clever clinician, who, under the influence of Sharpey, had in 1866 carried out some physiological experiments on respiration at University College, followed him as lecturer in Practical Physiology, with the understanding that he would have the chair of Physiology on Sharpey's retirement. This clinician was Dr. John Scott Burdon-Sanderson. Here was another Edinburgh graduate in medicine (1851), who had joined the group in Paris immediately after taking his degree. His diary of this period gives us brief pictures of his life there, now attending lectures and laboratories with students whom he had known at home, Harley, Pavy, and

others, now reading before the Paris Medical Society a paper "which was not understood." On March 1, 1852, there is the following entry in the diary: "Went with Marcet to Bernard's, who showed us much attention." This is followed the next day by "Went with Harley and Mason to Bernard, who introduced us to Magendie!" On March 13, 1851, occurs the entry, "Was with Bernard performing several experiments." Among other entries scattered along the diary are the following: "Performed operation for obtaining pancreatic juice on a rabbit; did not succeed in introducing the cannula"; "injected a pigeon"; "operated unsuccessfully on a dog for pancreatic juice"; "operated successfully on pancreatic duct," etc. A more elaborate notebook of this date in his handwriting gives a synopsis of Bernard's experimental lectures, and treats some subjects in much detail, notably, the rôle and nature of glycogen and the phenomena of diabetes. In fact, he "seems to have fallen under the magnetic spell cast by the intellectual personality of the great physiologist." His veneration for Bernard lasted throughout his life, and in later years he used to say, pointing to the bust which stood upon the shelf above his study table, that Bernard was the most inspiring teacher, the most profound scientific thinker and the most remarkable experimental physiologist that he had ever known." In 1883 Burdon-Sanderson left London to accept the chair of Physiology at Oxford.

Thus, at London, Cambridge, and Oxford, the tradition of Bernard's teaching was carried on, and carried on so effectively that at the beginning of this century preëminence in physiology passed from France to England.

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## CLINICAL NOTES AND CASE REPORTS

### LYMPHOPATHIA VENEREA

By ANTHONY B. DIEPENBROCK, M.D.

JAMES J. MCGINNIS, M.D.

RODNEY A. YOELL, M.D.

AND

JAMES W. MORGAN, M.D.

San Francisco

**T**WO cases of local (San Francisco) origin of Lymphopathia venerea (Lymphogranuloma inguinale), conjugal, are herewith reported.

**CASE 1 (Husband).—**A. P., an Italian male laborer, age thirty-two, consulted one of us (Diepenbrock) at his office on December 6, 1929, on account of a painful swelling in the left groin, producing difficulty in walking, chilly sensations, profuse perspiration, and fever. About ten days previously he observed a small painless papular lesion on the glans penis, which disappeared in a few days. Three or four days later pain and tenderness developed in the left groin, followed by a small, tender swelling, which grew larger, until finally he became disabled. He admitted coition during the middle part of November with an unknown person picked up on the streets. He also admitted subsequent coitus with his wife who, at the time, was about eight and one-

half months pregnant, and at this time was in the hospital after her accouchement.

Physical examination was generally negative, except for the left groin, which presented an exquisitely tender, firm, non-fluctuating, irregularly nodular mass occupying a large part of the inguinal region. This apparently represented a large number of confluent, enlarged lymph nodes, together with a great deal of inflammatory subcutaneous tissue involvement. The overlying skin was discolored with a purplish erythema, and was not movable over the mass, while the mass itself was fixed to the underlying tissues. At this time there was no remaining evidence of the penile sore, and there was no urethral discharge. However, a urethral smear was made and found negative for gonococci; a prostatic smear likewise showed no gonococci. The Wassermann was negative. The blood count showed nothing worth noting. The urine was normal.

The patient was sent to St. Mary's Hospital, where complete excision en masse of the contents of the left groin was made by Dr. Rodney A. Yoell, and the wound permitted to heal by third intention.

Subsequently the patient had an intermittent fever with daily fluctuations up to 102 degrees Fahrenheit for about eight days, followed by another week with lower daily fluctuations. At the end of twenty-two days, on December 28, 1929, he was sent home, although the wound had not as yet healed. On February 13, 1930, he reentered the hospital; this time on account of swelling tenderness, redness, and pain in the right groin, and a recurrence of the swelling in the left groin. The previous operative wound had completely healed, but just below it was a mass about 2 centimeters in diameter, painful to the touch, not fluctuant, and firm. It had the appearance of a large lymph node. The overlying skin was normal. The right side gave the same appearance as the left side on the previous entry. At this time the temperature was normal. Two days later an en masse excision of both groins was done; the patient made an uneventful recovery and was discharged, with both operative wounds healed, on the 11th of March.

Pathological examination of the tissue removed showed that it consisted of enlarged lymph nodes in thick fat, with several cavities containing a thick, creamy, odorless purulent material. Microscopically, the lymph nodes were edematous, with small abscess cavities and much leukocytic infiltration. There was nothing in the specimen suggestive of tuberculosis. Smears from the purulent material showed no organisms of any kind. Cultures and tissue sections showed no bacteria.

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**CASE 2 (Wife).**—G. P., an Italian housewife, age twenty-five, wife of the first patient, on December 2, 1929, entered the hospital, where on the following day she gave birth to a full-term, normal, male child. On December 16, 1929, she was discharged, recovered from her accouchement but complaining of small, painful lumps in both groins. She was treated at home with hot fomentations, but the swellings became progressively greater and more painful. There were no chills or fever.

On February 11 she was forced to reenter the hospital. At that time examination revealed a group of enlarged, painful, tender, slightly fluctuating lymph nodes in both groins. Each mass occupied almost the entire inguinal region. The overlying skin was reddish violet in color on both sides, and fixed to the mass. The Wassermann was negative. Vaginal and cervical smears were negative for gonococci. The blood count was normal; the urine, negative. The general physical condition otherwise negative. On February 12 complete excision of both inguinal masses was done by Dr. Rodney A. Yoell. Subsequently she made an uneventful recovery, and was discharged with wounds healed on March 11, 1930.

Examination of the removed tissue revealed a condition identical with that of her husband. Smears and cultures were negative for microorganisms. Tissue sections revealed no bacteria. The lymph glands were enlarged, edematous, fibrotic in places; while in other places there was marked leukocytic infiltration with softening, and multiple minute and gross abscess formation. The neighboring fat was filled with lymphocytic infiltration. Outside the fibrous layer surrounding the abscesses were a few large, mononuclear giant cells with centralized nuclei.

On June 21, 1931, she was again admitted to the hospital on account of a marked hydrops articuli in both knee-joints. Other joints were normal. The Wassermann was again negative; the blood count, normal; the urine, normal; the general physical condition was good. Both groins were normal, except for operative scars. No enlarged glands were noted anywhere. The temperature was slightly elevated. Vaginal and cervical smears were negative for gonococcus and Ducrey's bacillus. Repeated paracentesis of both joints was done, and various amounts of fluid removed. The fluid was a clear, amber-colored, viscid fluid without sediment, containing some polymorphonuclear leukocytes. The specific gravity was 1.027. A strongly positive Rivalta's reaction proved its exudative nature. Smears and cultures were negative for microorganisms. On July 13 bilateral tonsillectomy was done, and thirteen days later the patient was discharged from the hospital, with normal knee-joints and feeling well. In January, 1933, she had a recurrent hydrops of both knees. Repeated paracentesis again gave relief.

In August, 1933, she consulted one of us (Diepenbrock) at his office on account of lack of appetite, nausea, vomiting, abdominal cramps, loss of weight and constipation. Examination revealed an annular stricture of the rectum too small to admit the examining finger. Proctoscopically the mucous membrane of the rectum was normal up to the margin of the stricture, which was glistening. No masses were present and no induration could be detected. Upon removal of the proctoscope, thick, bloody pus was evacuated. No abdominal masses could be detected. The perineum, vulva, and anus were normal. No masses could be felt vaginally. The uterus and adnexa were normal. No pelvic tenderness could be elicited. The Wassermann once more was negative. There was a slight leukocytosis, and also slight fever. The urine was negative.

On August 24 she was sent to the hospital where, on the 25th, a laparotomy was done. The rectum was found thickened, congested and edematous. Proctoscopically, a section of the stricture was removed; then colostomy was performed. On September 9 she was discharged from the hospital, having gained weight and strength, while the artificial anus performed its proper function.

Histological examination of the tissue removed revealed a dense, granulating tissue with scarring and lymphoid structures resembling the solitary follicles of lymph glands. The epithelium showed no invasive characteristics.

On December 21, 1933, Dr. James J. McGinnis was finally able to obtain a small amount of Frei antigen through the courtesy of Doctors Cole and Conner of Cleveland, Ohio. On the same date both patients were inoculated, intradermally, with 0.1 cubic centimeter on the ventral surface of the right forearm. At the same time a similar inoculation was given a normal person. The next day the two patients revealed at the site of the inoculation a circular area of bluish erythema, approximately 2 centimeters in diameter, in the center of which a firm nodule was noted. The control was negative.

At the present time the patient receives frequent dilatation of her stricture, while the colostomy continues to divert the fecal stream.

The male patient has remained well to date.  
450 Sutter Street.

## A CASE OF DIABETES INSIPIDUS\*

CONTROLLED WITH POWDERED PITUITARY  
POSTERIOR LOBE EXTRACT APPLIED  
INTRANASALLY, AS SNUFF

By C. KELLY CANELO, M.D.

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AND

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San Francisco

## REPORT OF CASE

THE patient (A. O. L., UCHOPD, No. 207357), a single male, age forty, was in good health until the age of twenty-two, when he contracted typhoid fever. During convalescence he developed polyuria and polydipsia, which amounted to some eight or nine liters daily. The condition persisted up to the time of entering the hospital, November 16, 1931.

His past history, otherwise, bore no relation to his present complaints, nor did the family history.

Physical examination revealed no significant abnormalities. Laboratory investigations showed a normal blood count; normal glucose tolerance curve; negative blood and spinal fluid Wassermann. An x-ray of the sella turcica showed it to be within normal limits, and the skull otherwise disclosed no abnormalities. The Volhard test gave a concentration of 1.003-1.005-1.004. In other respects, the urine was normal.

During the patient's hospital stay it was found that the fluid intake and output could be maintained at about two liters daily by the administration of obstetrical pituitrin, one cubic centimeter, hypodermically twice daily. Accordingly, the patient was discharged from the hospital on this dosage and transferred to the out-patient department, where he has been observed for the past two years.

During this period various approved treatments were tested in an attempt to find which method would prove most efficient, easily administered, and economical.

The accompanying chart shows the results of the several procedures tried. It was not convenient for the patient to measure his fluid intake; however, since his weight remained stationary, the fluid output can be reasonably regarded as an index of efficiency of treatment.

On one cubic centimeter obstetrical pituitrin hypodermically, twice daily, his fluid output was maintained at from 2,080 to 2,240 cubic centimeters for a period of two months.

The next month, treatment was modified by administering one cubic centimeter surgical pituitrin, hypodermically, *once* daily. On this regimen the polyuria and polydipsia were controlled for from eight to nine hours, followed by a prompt return of excessive thirst and polyuria.

The following month, only one cubic centimeter daily of obstetrical pituitrin accomplished control of symptoms practically identical with his experience, while using the double strength pituitrin S preparation.

Upon resuming the original routine of one cubic centimeter obstetrical pituitrin twice daily, the daily fluid output was again controlled at from 1,920 to 2,240 cubic centimeters.

It was then decided to try, next, powdered posterior lobe pituitary extract, grains one-tenth, as a snuff, to be inhaled three times a day. This procedure maintained his fluid output between three and four liters. Upon increasing the medication to grain one-fifth three times a day, the output was reduced to three liters daily.

Although this dosage was fairly satisfactory, especially during the daytime, the patient was annoyed by thirst and voiding during the night. Accordingly, a fourth dose at bedtime was recommended. This per-

mitted him to enjoy a full night's rest. His output now ranged from 2,080 to 2,240 cubic centimeters.

At this time the patient ran out of funds and was, therefore, forced to stop treatment; whereupon the fluid intake and output promptly rose to from 5,760 to 6,080 cubic centimeters, with the original distressing symptoms of polyuria and polydipsia, together with serious interruptions of sleep as a result. A return to the snuff therapy (powdered posterior lobe pituitary extract) once again controlled the fluid output at about 2,560 cubic centimeters daily.

This was continued until July, 1933, when it was thought desirable to test the effect of amidopyrin, grains five, four times daily. From the chart it can be readily seen that this treatment did not prove satisfactory, for his output promptly rose to between 4,960 and 5,280 cubic centimeters.

Again returning to the treatment with powdered posterior lobe pituitary extract snuff, grain one-quarter, four times daily, his intake and output were controlled at from 1,920 to 2,240 cubic centimeters daily, and have remained within these limits for the past eight months. The patient gets from eight to nine hours of uninterrupted sleep—a "Utopia" for one suffering from diabetes insipidus. There has never been any nasal irritation or other discomfort from his use of the snuff.

## COMMENT

In 1913 Farini and Ceccaroni, as well as Veldon, independently demonstrated for the first time the value of injections of posterior pituitary extract in controlling the symptoms of diabetes insipidus. This therapy proved efficient in the case here reported.

Because our patient was in quite limited financial circumstances, and because he found it necessary to tour around from time to time seeking work, traveling by automobile and staying in temporary camps, hypodermic medication was not entirely satisfactory, so it became imperative to search still further in an endeavor to obtain satisfactory control of his ailment.

Pitressin has been demonstrated by Kamm to be more specific than pituitrin; but, as stated above, hypodermic treatment was not feasible. The same objection applied to intermedin.

Motzfeld (1918) reported a case of diabetes insipidus, in which the symptoms were controlled by feeding fresh posterior pituitary lobe of the ox. Rees and Olmstead (1922) successfully controlled a case on desiccated posterior pituitary put up in salol-coated capsules. However, Christian and Blumgart found posterior pituitary by mouth, in salol capsules, or colonic irrigations, ineffective in their cases. Blumgart claimed that it must be administered either by injection or intranasal application—as a spray, saturated pledgets of cotton, or as a snuff powder. He stressed the advantage of the intranasal route over hypodermic medication, since it does not produce the not infrequent distressing side-effects of pituitrin injections, viz., local soreness and swelling at the site of injection, nausea, abdominal discomfort, pallor, palpitation, and syncope.

Mettel (1929) reported a case of diabetes insipidus in a girl, aged nine, who responded to treatment with solution of pituitary dropped into the nose, three times daily, by means of a medicine dropper.

Blumgart controlled four cases by spraying the posterior pituitary liquid into the nose; and in an-

\* Read before the Pacific Interurban Clinical Club at the University of California Hospital, San Francisco, December 14, 1934.

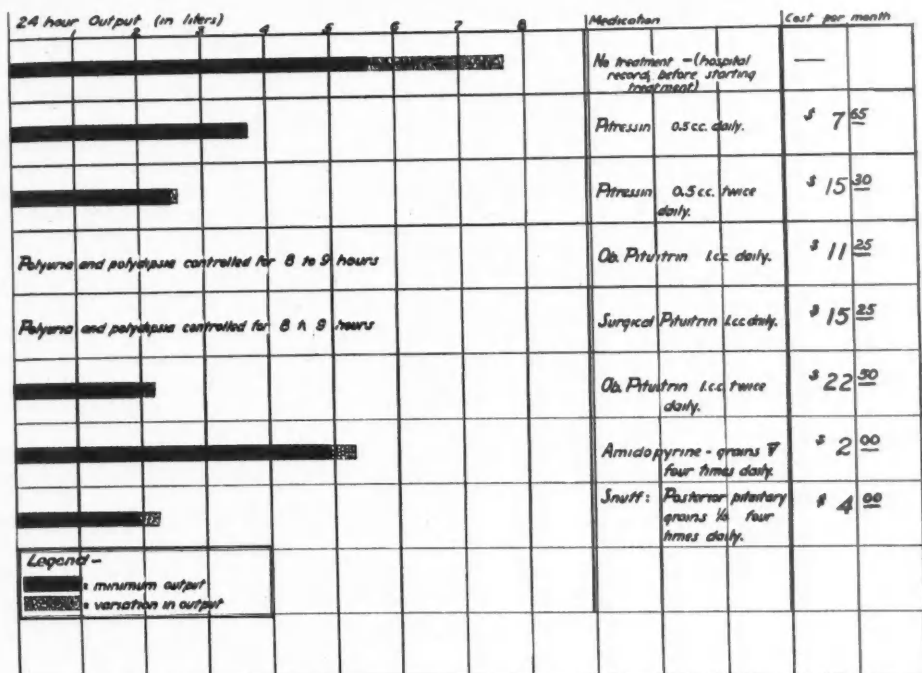


Chart 1.—A case of Diabetes Insipidus showing the efficiency and cost of various medications.

other series of eight cases Campbell and Blumgart were similarly successful with a spray of one-half to one cubic centimeter obstetrical pituitrin, used every three to six hours. In these latter cases the same dosage on a cotton pledget proved equally satisfactory, when introduced into the nose.

Andrey (1924) showed that the symptoms of diabetes insipidus could be relieved by snuffing 50 milligrams of dry powdered posterior lobe pituitary three times daily. Later Rosenberg, Vidgoff and Smith reported cases successfully treated by this method. Vidgoff, in his report, showed that pituitary jelly was less effective and more expensive than the posterior lobe pituitary snuff.

The writers chose the snuff as the method of choice for intranasal administration of posterior lobe pituitary substance, since it offers the most convenient, as well as the most economical means of treatment. Each dose is accurately weighed out and dispensed by the pharmacist in a "powder paper." When it is time to take his medicine the patient simply unfolds the paper, rolls it up similar to a "sipping-straw," inserts one end into the nose, sniffs the powder, and he has no further worries until time for his next treatment. Whether he be in an otorhinolaryngologist's office or traveling along the isolated country highway in his automobile, his medication is administered equally satisfactorily.

Because Scherf, in 1932, and Kahn, in 1933, reported some success in treating diabetes insipidus with amidopyrine, it was deemed appropriate to check its action in our patient; but reference

to the chart will demonstrate its inefficacy, at least in this case.

The economy of this efficient and convenient method of treatment becomes apparent in the determination of comparative costs, a point of no mean importance when it is realized that treatment must be continued for life. Our patient, if treated with obstetrical pituitrin, one cubic centimeter twice daily, whether hypodermically or in a spray, will require sixty ampoules per month, at a cost of from \$13 to \$15. One month's supply of snuff, however, consisting of 120 measured doses of powdered posterior lobe pituitary substance, grain one-quarter, individually wrapped, will cost the patient \$4. A rather formidable saving of about \$100 per year—and with an equally efficient form of therapy.

#### CONCLUSIONS

1. A case of diabetes insipidus of eighteen years' duration, which developed during convalescence from typhoid fever, is herein reported.
2. Powdered posterior lobe pituitary substance as a snuff and pituitrin hypodermically controlled the symptoms equally efficiently. Amidopyrine failed to relieve him.
3. The snuff treatment was more easily administered, and strikingly more economical.
4. The literature on the treatment of diabetes insipidus is reviewed briefly.

Medico-Dental Building.

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### THE MECHANICAL RESPIRATOR\*

A BRIEF SUMMARY OF CASES TREATED AT  
 SAN FRANCISCO HOSPITAL

By J. C. GEIGER, M.D.  
 San Francisco

OF twelve individuals treated, ten were affected by acute anterior poliomyelitis, in which respiratory paralysis had occurred, and two were affected by measles complicated by postmeasles pneumonia.

In the latter group there was one boy (age, eight years) who recovered, and one girl (age, four years) who died.

Of the former group, there were four males (ages four, twenty-three, twenty-six and fifty-three years) of whom but one recovered (age four years); but this boy was of non-local residence, and it is not known whether finally he recovered. There were also six females (ages sixteen, twenty-two, twenty-two, twenty-three, twenty-six, and twenty-six), none of whom recovered.

In the postmeasles pneumonia cases, the boy was in the hospital forty-eight days, while death in the girl occurred four days after admission.

In the poliomyelitis group the boy who did not die in the hospital in San Francisco, but in whom the ultimate outcome is not known, was treated for only five days, when he was returned to his home by airplane; but the duration of the hospital care given the others varied from less than one day (age fifty-three years) to fifty days (age twenty-three years).

Death, when it occurred after an interval of more than two days' treatment in the respirator, was found to be due to hypostatic or bronchopneumonia. In those instances, however, in which death occurred following a shorter interval, bulbar paralysis was given as the immediate cause of death.

It is believed, therefore, from this brief study of a small series of cases, that there is justification for skepticism toward the actual benefit to be derived from treatment with the respirator or

any other type of "mechanical lung." It is certainly evident that life may be prolonged, and this may be sufficient to encourage the use of the device; but little confidence may be placed, it is believed, in the rather remote possibility that the function of the respiratory muscles will return before pneumonia of one or another type develops because of the incomplete aeration, and the effects of the positive-negative pressure phases, including the inadequacy of provision for proper general care and hygiene.

It is not meant to convey the impression that the device is to be condemned or not used, if available. Assuredly it is not a complete substitute for the lost respiratory function. Moreover, its value in suitable cases of acute anterior poliomyelitis even after prolonged use, as far as the final clinical outcome of the disease itself is concerned, appears to be doubtful.

San Francisco Hospital.

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*How to Prevent Common Colds.*—How can we prevent a cold? Since we know that colds are catching, we should make every attempt to avoid close contact with those who have an acute cold. This is particularly important during the first three days of the disease.

Some exposure is unavoidable. There are a few simple rules to follow, however, which probably aid in preventing colds, even if one is exposed. The rooms in which we live should have a suitable temperature and humidity. The superheated air of an office or apartment may reach a temperature of 80 degrees. The air becomes as dry as that of a desert so that the membranes of the nose and throat become parched and cannot perform their normal protective functions. This condition predisposes to colds.

*Are Wet Feet Harmful?*—The body surface should be kept warm and dry. If the skin becomes chilled, one is apt to catch cold. Mothers worry when their children play in the snow or rain and get their feet wet. Wet feet are not harmful so long as the child is active and exercising, but if a person sits quietly in school or office all day with wet feet, the body surface becomes chilled, thus predisposing to a cold.

Many people believe that alcohol is of value in preventing colds. When one is chilled, alcohol does give a feeling of warmth, but causes flushing of the skin and great loss of heat. If one is continuously exposed to the cold, as on a long drive in freezing weather or working all day in the cold rain, a series of drinks of whisky may do real harm. When one finally comes in from a long, cold trip, however, all wet and chilled, shivering and cold, and does not need to go out any more that day, a reasonable drink of alcohol is of definite value in bringing about a rapid flushing of the skin and a warm, comfortable glow. The same effect may be obtained, though somewhat more slowly, with a hot mustard foot bath and a drink of hot coffee.—Dr. Wilson G. Smillie, Professor of Public Health Administration, Harvard University School of Public Health.

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One of the most important lessons that we should appreciate is the great complexity and the vast scope of the field of public health. It is not a definite science but comprises a great body of knowledge about as broad as experimental science itself. For that reason the study of public health should be excellently adapted for general educational purposes. In this field, not only are the fundamentals of practically every laboratory science applied, but here is ample opportunity for the study of classics, the humanities, social problems and economics; for all civilizations have been profoundly influenced by problems of health and disease.—D. J. Davis, M.D.

\* From the office of J. C. Geiger, M.D., Director of Public Health, City and County of San Francisco.

## BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

### ENDOCRINE PREPARATIONS AND THEIR CLINICAL USEFULNESS

#### I

##### THYROID SUBSTANCE

H. LISSER, M. D. (384 Post Street, San Francisco).—One might well wonder how and when the clinical field of hormonotherapeutics would have developed had it not been for the fortunate circumstance, discovered forty years ago (1892), that dried thyroid substance orally ingested utterly transformed myxedematous children and adults. This simply applied and amazingly effective remedy stimulated and buoyed the hopes of those investigators who since then have striven to produce similar successes with preparations from the other ductless glands. Thirty years elapsed before the second marvel appeared, insulin. This again spurred on renewed enthusiasm, and the past decade has witnessed the isolation of several remarkable substances from the parathyroid glands, the anterior hypophysis, the adrenal cortex, and the male and female sex glands.

For the present, however, and perhaps for some years to come, thyroid substance will remain the most valuable incretory extract of them all, with the widest clinical applications. It is preëminently useful. It is easy to administer and control. Unfortunately, there continues lamentable ignorance of when and how to prescribe it, and injudicious hostility toward it, with misguided propaganda concerning its exaggerated dangers.

Myxedema in full-blown form is relatively uncommon, but probably less so than generally supposed. Hardly another disease can be mentioned wherein such truly miraculous changes may be wrought, and hardly another ailment can be thought of which is so consistently mistaken. If this be true for outright myxedema—and it is true—how infinitely more so does it hold true for the more frequent and less characteristic or partial forms of the disease, and for the milder grades of hypothyroidism!

Considerations of brevity permit only a mere listing of symptoms and signs sometimes caused by inadequate thyroid function. The reader who wishes to pursue this further is referred to a recent article by Lissér.<sup>1</sup>

Circulatory phenomena: Fatigue, dyspnea, orthopnea, bradycardia, "myxedema heart," with dilatation of all chambers and specific progressive

shrinkage under thyroid therapy; flattening or inversion of T-waves, sometimes in all three leads; abnormal axis deviation, small P, notched and widened Q. R. S. complexes, quite common; moderate hypertension; even heart-block and hydrothorax.

Gastro-intestinal phenomena: Constipation, even obstipation, achlorhydria, abdominal pain, hepatic dysfunction, diatheses of infancy (vomiting, intestinal colic, etc.), and even megacolon and ascites. Anemia with weakness and weariness is a common symptom. This hypothyroid anemia may be quite severe, occasionally with high color index, and frequently with achlorhydria, leading to a diagnosis of atypical pernicious anemia. Such patients may have a pasty, slightly yellowish complexion, sometimes with a malar flush.

Arthritic symptoms, such as achiness and stiffness in various joints or muscles, are not uncommon manifestations of hypothyroidism.

Menorrhagia and metrorrhagia may be the presenting complaint. Atony of the urinary bladder has been reported in myxedema, and relieved by thyroid substance.

Puffiness of the eyelids, impairment of hearing, giddiness, vertigo, tinnitus aurium, snuffles, chronic hoarseness—any one of these may be consequent to thyroid deficiency.

Roughness and dryness of the skin, absence of perspiration, coarseness and loss of hair, sensitiveness to cold weather, even ichthyosis, keratoderma, pruritus, alopecia, and onychiauxis may have a hypothyroid basis.

Mental torpor, forgetfulness, inattentiveness, loss of initiative, stupidity (especially in hypothyroid children), lethargy, drowsiness, apathy, clumsiness, and even severe melancholia, mania, hallucinations and delusions may depend on thyroid inadequacy.

Dwarfism may be a striking characteristic of childhood myxedema. Obesity is a common finding in children and adults with low basal metabolic rates. Even allergic states have at times been relieved by thyroid substance.

This kaleidoscopic array of symptoms illustrates the capricious vagaries of hypothyroidism. Many of them may occur in one individual; more often only a few are present and so dominate the patient's complaints that the physician is led astray, and the underlying common denominator of thyroid failure is unrecognized. It is important, therefore, to keep in mind these hidden hints of myxedema, since they respond so satisfactorily to thyroid therapy.

<sup>1</sup> Lissér, H.: The Clinical Indications for and the Proper Use of Thyroid Substance, International Clinics, Vol. IV, Forty-Third Series (December), 1933.

Thyroid substance has been therapeutically helpful in some conditions not necessarily of thyroid origin, such as parathyroid tetany, progressive axial myopia, thrombo-angiitis obliterans, lipid nephrosis, asthenic states, and nonthyroid obesity.

Basal metabolic rate determinations, roentgenographic determination of bone age in children suspected of hypothyroidism, and blood cholesterol values, are helpful technical aids in diagnosis and in controlling treatment, but must be interpreted in conjunction with the anamnesis and physical examination and clinical response to treatment. The blind acceptance of a laboratory report may lead to serious error. The physician must be self-respecting enough of his clinical legs to stand on them firmly, and not be swept off his feet by a laboratory test. A markedly subnormal basal rate does not, *ipso facto*, signify hypothyroidism; nor does a normal rate necessarily exclude it.

It is obvious that thyroid should never be administered to an individual who is already suffering from too much of it. Why add fuel to the flames?

It probably makes little difference which brand of thyroid, thyroxin, thyreodin, or thyraclin, etc., the physician selects, since all of them are potent, so long as he sticks pretty well to one of them and becomes intimately familiar with its action. There is such a thing in clinical practice as "getting the feel" of a preparation, and from long experience gauging fairly accurately the appropriate dose for a given degree of thyroid deficiency in a particular type of patient.

Remember that one grain of the "desiccated substance" is equivalent to approximately five grains of the "fresh substance."

Begin with a relatively small dose, such as one-half grain of the desiccated substance once or twice daily; increase gradually and keep your patient under weekly observation until you have reached the proper maintenance dose.

At first thought one would expect to be guided in estimating the proper dosage by the depth of the basal rate—that is to say, the more subnormal the rate the larger the dose; but this concept is quite erroneous. Indeed, the opposite is more nearly correct. The greater the basal depression and the more profound the myxedema, the more delicate the response to thyroid substance. Patients with frank myxedema and basal rates of 30 to 50 minus are quite susceptible to relatively small doses of thyroid extract, and rarely require more than four grains daily of the desiccated substance to elevate the rate to a normal level; and usually two grains daily suffice to maintain it there.

The following symptoms should excite suspicion of overdosage: Nervousness, excitability, fidgetiness, irritability, insomnia, excessive perspiration and feeling of heat, palpitation and dyspnea, subjective sensation of pounding and racing heart action, diarrhea, scanty menses or prolonged menstrual intervals, especially if these symptoms are

new phenomena, or, having existed before, are now materially increased. Objective confirmation is furnished by undue loss of weight, toxic appearance with anxious staring eyes, agitated demeanor, undue talkativeness, tachycardia, forceful heart action, rapid fine tremor of the extended fingers, enlargement of the thyroid gland with thrill and bruit, and elevated basal metabolic rate—in other words, the symptoms and signs of hyperthyroidism. The appearance of any one or a number of these constitute a signal for decreasing the dose and, still better, discontinuing thyroid entirely for a few days or a week. There is no occasion for alarm on the part of either patient or physician, since the disagreeable symptoms will promptly vanish in from three days to a week, unless the toxic state has been permitted to continue for many weeks before a halt was called. After the toxic manifestations have subsided, thyroid should be resumed; but, of course, at a lower dose than the amount which provoked toxicity.

All of which means that no patient should be permitted to continue taking thyroid without remaining under periodic observation.

It is wise to warn all patients to report any new symptoms at once, and if they are at a distance which prevents their calling promptly, to discontinue the thyroid temporarily, especially during intercurrent infections with fever.

When vacation time approaches, or whenever patients are leaving on extended trips which may take them into great heat or altitudes over 3,000 feet, it is prudent to cut the dose in half at least, and sometimes to omit thyroid altogether. The same precaution is taken if any exceptional physical, mental or emotional strain is impending. Reference is made to such episodes as an athletic contest or tournament, an operation, college examinations, intense business conferences, marriage ceremony, serious illness or death of a close relative, etc.

It is time to stem the tide of exaggerated fear of this valuable hormone which has obsessed a considerable part of the medical profession for the past twenty years. No potent drug is harmless, but thyroid administration is one of the simplest to control. The profession is responsible for instilling and fanning alarm in the public. It is diverting to notice how often we turn out to be our own worst enemies.

It is high time that the public's blaze of fear concerning thyroid therapy (by a physician) be permitted to consume itself; indeed, some quenching of it, and even some back-fire, by ourselves, would not be inappropriate.

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#### EXTRACT OF ADRENAL MEDULLA

FLETCHER B. TAYLOR, M. D. (400 Twentieth Street, Oakland).—Epinephrin is one of the few potent biologic products. It can be synthesized, but the best source for commercial purposes is the medulla of the adrenal glands of beef. Its

usefulness lies in its power to activate involuntary tissues, as if sympathetic nerve supply to such tissues were being stimulated. It relaxes bronchial spasm, lessens gastro-intestinal peristalsis, increases the available sugar in the blood, raises the blood pressure, and controls urticaria in some of its useful physiologic expressions. How may it be used effectively, and what are the dangers involved?

1. When applied to mucous membrane, it shrinks the membrane, blanches it, decreases the flow from bleeding points, checks the discomfort caused by allergens, is not absorbed to any great extent by circulating body fluids, and is not dangerous.

2. When used subcutaneously it has local effects similar to those just described, but it is made available to body fluids by this route. It has, therefore, systemic effect when thus given. But still it is not dangerous in ordinary doses. Dr. Chauncey Leake reports that there are no deaths recorded in recent years from the subcutaneous injections of epinephrin alone. One-quarter milliliter of the usual 1-1000 dilution is a small dose; one milliliter is a fairly large one.

3. When used intravenously or when injected into heart muscle, both the power and danger are multiplied by twenty, as compared with avascular injection. One milliliter of 1-1000 epinephrin will kill a two-kilo rabbit when given intravenously. The mechanism of death involves rise in blood pressure and the development of lung edema.

How may epinephrin be used safely by vein in the treatment of serious shock?

What patients are poor subjects for intravenous injection of epinephrin?

4. A young person with good heart muscle, who has obvious shock following surgical operation or injury, may be sometimes saved from death by the intravenous injection of one to four milliliters of epinephrin, diluted in physiologic saline solution and injected during a total period of one hour or more.

5. An elderly person with poor heart muscle may be killed by the procedure just outlined. But if the condition is surely one of shock and not of heart failure, a smaller amount per unit of time may be used despite the risk involved.

What of the mixture of epinephrin with local anesthetic?

6. This is a very convenient mixture for the surgeon, but the toxic effects of the anesthetic are increased in the presence of epinephrin.

7. Large amounts of such mixtures are used with impunity in surgical work about the abdomen or extremities.

8. The surgeon who works with submucous injections, *e. g.*, in the nose, the mouth or the gums, may well assume that he is making intravenous injections of his material. That attitude of mind may save unnecessary reactions and accidents.

The patient whose tolerance is doubtful should have a test dose given on a day separate from the

day of operation. After the dose, blood-pressure readings and observations for lung edema can be taken and recorded at fifteen-minute intervals for an hour. This will help in the recognition of those patients who have bad psychic or physiologic reactions.

Two other practical considerations may be worth mentioning:

9. A potent solution of epinephrin is white or straw-colored. Oxidation changes it to a garnet color and makes it useless. A sealed ampoule of white glass protects the solution and allows its color to be easily seen.

10. A one-ounce, corked bottle of 1-1000 epinephrin solution costs the doctor about one dollar. Synthetic epinephrin costs about one-half as much and is about one-half as potent. Single milliliter ampoules increase the cost threefold over the cost by the ounce. The corked-bottle content deteriorates more rapidly than the ampoule content, and is less certainly sterile, despite the presence of five-tenths per cent chloreton. Why may not epinephrin solution be carried in the vaccine type of bottle with rubber cap, thus combining the three advantages of sterility, prolonged potency, and economy?

#### EXTRACT OF ADRENAL CORTEX

The only commercially available product of adrenal cortex which has a proved potency is the "Eschatin" of Parke-Davis. This costs, to the doctor, \$6 per ten milliliter bottle. Its most practical value is to the patient with Addison's disease in a period of acute relapse. It may then be given by vein in amounts from 10 to 50 cubic centimeters, and has often saved lives when thus used. But what of the use of maintenance doses for those patients who are chronically disabled over long periods? One or two milliliters, three to seven times per week, have been used with variable success between relapses. Dr. Hans Lissner computes the cost at or near \$1,000 per year for patients observed by him. This makes it economically impossible for the average patient. There are other discouraging features in its use. Steady maintenance dosage usually requires gradually increasing amounts. Dr. William Fitch Cheney has had the most cheerful experience known to me, having maintained a patient with Addison's disease in good health for three years with a daily dose of two milliliters. The efficacy of the extract may be enhanced by Doctor Harrop's plan of encouraging the free use of sodium chlorid at the table, plus one to seven grams daily in capsules. Eschatin is intolerably painful to some patients when given into the muscle. I know of no accidents from its use in the vein.

\* \* \*

#### PARATHORMONE

H. CLARE SHEPARDSON, M.D. (384 Post Street, San Francisco).—Although Sandstrom (1880) first specifically described the superior or external pair of parathyroid glands, he left unsettled their

possible physiological function. Later (1891) Gley rediscovered the superior pair and instituted a notable series of experiments to determine their functional pathology.

In spite of his erroneous idea that the parathyroids could compensate for the extirpated thyroid gland by differentiating into thyroid tissue, Gley's experiments provided two important results. An explanation was afforded for the difference in the results of thyroidectomy in carnivora and herbivora. In the latter, due to the anatomical location of the parathyroid glandules, tetany was usually escaped following thyroidectomy. Of even greater importance, however, numerous investigations were stimulated to attack various problems relating to the parathyroids.

Thus Kahn (1895) is credited with the actual discovery of the inferior or internal pair of parathyroid bodies and, furthermore, he was the first to insist that these glandules are organs anatomically separate and functionally distinct from the thyroid gland. In the following year (1896) Vassale and Generali demonstrated a definite relation between extirpation of the parathyroids and the convulsive attacks known as postoperative tetany which occasionally followed subtotal thyroidectomy. These observations were eventually confirmed by the work of Nicholas and Swingle (1924), which afforded conclusive evidence that complete removal of the parathyroid glands results directly in a specific syndrome of symptoms and death. As a result, "tetania thyreopriva" became "tetania parathyreopriva." Any doubt which may have existed subsequent to this latter work was completely removed by the masterful researches of Collip, culminating in the isolation by him (1925) of a potent parathyroid extract. This extract contained the active principle of the parathyroids, and injections of the substance uniformly prevented or relieved tetany in thyroparathyroidectomized dogs. Collip was, therefore, able to offer confirmatory evidence to the ideas expressed by MacCallum and Voegtlin, as far back as 1909, that the function of the parathyroid glands is to regulate the calcium exchange in the body. These writers considered that all the symptoms following parathyroidectomy were due to calcium deficiency, and Collip showed that the probable manner of action of the parathyroid hormone is through a direct effect on calcium metabolism. The use of this extract restores to normal the abnormally low-blood serum calcium of tetania parathyreopriva. Furthermore, the injection of this extract into normal dogs causes an elevation of the blood serum calcium value and, if continued, causes death from hypercalcemia.

The discovery and preparation by Collip of the hormone of the parathyroid glands have afforded in recent years an opportunity for diverse and elaborate investigations concerning its physiological properties. All authorities are at present agreed that its chief rôle consists in its important influence on calcium and phosphorous metabolism.

In the matter of the injection of parathyroid extract, Collip produces four cardinal effects: (a) rise in serum calcium; (b) rise in urinary calcium excretion; (c) fall in serum phosphorus; and (d) rise in urinary phosphorus excretion. Contrariwise, it has been shown that parathyroidectomy results in (a) fall in serum calcium; (b) fall in urinary calcium excretion; (c) rise in serum phosphorus; and (d) fall in urinary phosphorus excretion.

Inasmuch as the characteristic rôle of the parathyroid hormone, in relation to calcium metabolism, is mobilization, the chief source of calcium supply in the body should be mentioned. Aub and his co-workers have demonstrated that a long-continued high calcium diet results in an accumulation of calcium in the trabeculae of bone. On the other hand, prolonged administration of parathormone depletes this storehouse of readily available calcium. Apparently easily mobilizable calcium is not deposited in the bone shafts of adult animals.

At present seven diseases are recognized as associated with disturbance of calcium metabolism: Graves's disease, nephrosis, steatorrhea with megacolon, infantile rickets, osteomalacia, generalized osteitis fibrosa cystica, and tetany. Of these, probably only two are associated with lesions of the parathyroids—parathyroid tetany and its antithesis, osteitis fibrosa cystica (von Recklinghausen's disease).

Whether other systems and organs of the body, besides the nervous and osseous systems, are involved in disturbances of parathyroid function, is not settled at present. The evidence so far is conflicting as to whether the parathyroids are concerned with carbohydrate metabolism, or with liver function. There is a similar uncertainty in regard to the influence of the parathyroid hormone on gastric secretion and intestinal activity.

Parathyroid extract, Collip, is commercially available under the name "Parathormone." It is supplied in ampoules containing a certain number of "units per cubic centimeter." A unit of potency has been defined as 1-100 of that amount of extract which produces, on an average, a 1 milligram rise in blood serum calcium in 10 to 12 kilogram dogs over fifteen hours. It is injected subcutaneously or intravenously. There may be slight burning or pain at the site of injection (never severe), and sometimes the patient complains of abdominal cramps; otherwise, no unpleasant or ill effects are noted. The dose must be carefully controlled not only by the state of the patient, but more specifically by repeated accurate determinations of the blood serum calcium. The latter should not be permitted to rise to dangerous heights, for massive doses or repeated injections at short intervals produce a hypercalcemia in dogs which, if maintained, results in death. This extract cannot be given carelessly any more than one may trifle with insulin.

Parathormone is not efficacious when administered by mouth.

At present sufficient clinical investigations with this active parathyroid extract have been recorded to indicate its usefulness and specificity in tetany. Adequate evidence of its effectiveness in tetania parathyreopriva (postoperative tetany) has been recorded by Crile, Snell, and Lisser and Shepardson. Davidson has reported its use in a case of chronic tetany associated with myxedema and nephrosis. Collip and Leitch used it successfully in a case of tetany in a young child, and Hoag and Rivkin recorded its satisfactory effect in four cases of infantile tetany. Lisser, Smith, and Shepardson obtained brilliant improvement in a severe case of tetania gravidarum.

In addition to those pathologic conditions associated with hypoparathyroidism, or with lowered blood serum calcium resulting from parathyroid deficiency, parathormone has been used with considerable success in certain other abnormal states. Thus, a noteworthy advance in the treatment of lead poisoning has been contributed by Aub and Hunter. They found that the administration of parathyroid extract proved to be a more efficient and more rapid means of increasing the elimination of lead than any method heretofore employed. Likewise, parathormone injections, controlled by serum calcium estimations, markedly increased the elimination of the radioactive material, via the stools, in three cases of radium poisoning occurring in luminous-dial painters.

Huefer observed that parathormone has a strong vagotonic effect, causing a decrease in the pulse rate, prolongation of the cardiac systole, shortening of the diastole, hyperemia of the vessels of the abdominal organs. When the dosage of parathyroid extract is adjusted in such a way that the blood calcium level is raised to about 15 milligram per cent, a markedly increased excretion of urine may occur. Other workers have utilized this diuretic effect to advantage in such conditions as nephrosis, nephritis with edema, ascites as well as in eclampsia and allied conditions.

Parathormone has been employed in many other conditions, but the evidence accumulated to date is too fragmentary to be convincing.

It is difficult to give directions as to dosage. This must be individualized. The age and weight of the patient, the severity of the symptoms and the level of the blood serum calcium, constitute the data which should influence estimation of the dose. It is wiser to spread the effect over twenty-four hours by three or four injections at intervals of six to eight hours, rather than to administer one massive dose daily. Early in the course of the disease seven to fifteen units of parathormone daily will ordinarily elevate the depressed blood serum calcium occurring in tetany to a normal level and maintain it there. With adequate control of the blood calcium, larger doses may be given. In such conditions as lead poisoning, the dosage used has varied from twenty to one hundred units daily.

Since the chief object of the administration of parathormone, in most instances, is the mainte-

nance of a normal amount of circulatory calcium, it is usually wise to make available an adequate supply of calcium by means of its oral administration. Any soluble salt is obviously more assimilable than the phosphate or carbonate. Calcium lactate is the preparation ordinarily used, the dose varying from one to fifteen grams daily, although larger amounts are tolerated surprisingly well.

Finally, a word of caution should be added. In severe tetany the response to parathormone is a sensitive one, *i. e.*, the blood serum calcium will be affected by a much smaller dose than would be the case in a normal individual. Consequently, the law of specific hormone therapy, "a patient's sensitivity to a given hormone is in direct ratio to the need thereof," applies to parathormone just as it applies to other active gland extracts.

\* \* \*

#### INSULIN

E. KOST SHELTON, M. D. (34 West Micheltona Street, Santa Barbara).—The discovery of insulin, a story too well known to be repeated, marked a major turning point in the history of medicine. While it was previously conceded that health was dependent upon a balanced biochemistry, it remained for Banting and his co-workers to show the full import of this dictum. Up to this time diabetes mellitus, a particularly dread disease, had continued to stalk its prey relentlessly. The disorder was particularly fatal in children and thousands, administered to by a helpless profession, died before their time. One can appreciate what a profound effect the announcement of a "cure" for diabetes had upon physician and layman alike.

Those of us who were fortunate or unfortunate enough to have been in active practice at this time felt or rather hoped that insulin would prove to be a specific for diabetes. In other words, we were expecting a cure. It was not long, however, before this hope was definitely abandoned; for while insulin soon revolutionized the treatment of diabetes mellitus, one as readily learned of its limitations. This, of course, did not detract from its therapeutic importance, but led rather to deeper and more comprehensive studies in which insulin survives as an even more versatile boon to humanity. Carbohydrate metabolism, a subject which had baffled investigators since the time of Claude Bernard, became more thoroughly elucidated in the light of this discovery, and with it the knowledge that insulin is but a link in an endless physiological chain.

It has been shown that this remarkable hormone is dependent in a large measure upon other internal secretions for its degree of activity. Its secretion and effect are likewise subject to diet, exercise, the condition of the liver, the rate of absorption and elimination of foodstuffs, and last but not least, psychogenic factors. None of these complicating elements minimize the clinical usefulness of insulin, however—quite the contrary.

They, in turn, are dependent upon the active principle of the islands of Langerhans. Thus, insulin steps out of its heroic but rather limited rôle in the body economy and assumes a broader and more useful therapeutic position.

What is the present status of insulin in clinical medicine? In my mind, its usefulness may be roughly classified as follows:

1. In the treatment of diabetes mellitus and its complications.
2. In the treatment of underweight but otherwise normal (?) individuals.
3. In the treatment of individuals debilitated by disease or following serious operations.
4. In diagnostic procedures.

#### 1. *In the Treatment of Diabetes Mellitus and Its Complications.*

While the use of insulin in diabetes mellitus is well known to the average physician, a few remarks concerning its indications are in order. Given a patient in whom a tentative diagnosis of diabetes mellitus has been made, what should be the physician's procedure? He has the choice of either referring the patient to a diabetes specialist for an initial observation period, or of retaining the patient for himself. If the physician is passably familiar with carbohydrate metabolism in general, and the diagnosis and treatment of diabetes mellitus in particular, there is no reason why he should refer his patient; if he is not, there is every reason. Insulin is a potent hormone and, like all good things in medicine, has also the power to do harm.

Previously an individual presenting sugar in the urine was considered unquestionably as diabetic. Now we know that, in many instances, this is not true. Some individuals have low renal thresholds to sugar and may excrete sugar when the blood values are abnormally low. To give insulin to such an individual is not only poor medical practice, but actually dangerous. Therefore, one must depend upon blood sugar determinations. A blood glucose estimation on a fasting stomach (from twelve to fourteen hours after a meal) is informative in severe diabetes. A blood glucose taken two and one-half hours after a high carbohydrate breakfast (no specified amount) is more informative in a borderline case. But a glucose tolerance test is more or less conclusive. I say conclusive, but I do not necessarily mean that every individual possessing a low glucose tolerance (high blood sugar) is suffering from diabetes mellitus. The test is conclusive only in that it shows inadequate utilization of carbohydrate. Other disorders beside pancreatic dysfunction, *i. e.*, hyperthyroidism, hyperpituitarism, hyperadrenia, interfere with the metabolism of glucose and present just such a laboratory finding. If the diagnosis of pancreatic insufficiency or true diabetes mellitus is ultimately arrived at, one should have no fear of insulin. It is my belief that in this capacity too little insulin is employed.

I shall not attempt, in this brief article, to outline the treatment of diabetes mellitus. Suffice it to say that, in general, if a patient can be kept on a well-balanced and adequate diet, without showing blood glucose values over 150 milligrams per 100 cubic centimeters or acetone, and diacetic acid, or sugar appearing in the urine, insulin is obviously not indicated. If, on the contrary, the patient cannot be kept on a maintenance diet or one even slightly in excess of the maintenance level without producing these evidences of a physiological breakdown, insulin is definitely indicated. Never restrict the diet below adequate levels for the maintenance of health in order to avoid giving insulin. Such a procedure is inexcusable.

In diabetic coma insulin must always be given, quickly and in large doses. In all other diabetic complications, many of which are rarely seen in this age, insulin should take precedence over all other treatment, to be followed, of course, by suitable dietary and all other general and local measures designed for relief.

#### 2. *In the Treatment of Underweight, but Otherwise Normal (?), Individuals.*

Insulin of late has come into great favor as a stimulator of general metabolism in the treatment of the so-called typhus asthenicus or underweight individual. Many of these persons are free from objective evidence of disease. For cosmetic reasons or for relief of a vague train of symptoms, so commonly encountered, it has appeared advisable to raise their weight. This has been accomplished through dietary measures in the past with indifferent success. Insulin has developed into an important aid in such a regimen. Here again one should know something of the individual biochemistry before beginning treatment. I have repeatedly seen thin individuals who were already suffering from mild hypoglycemia (probably due to oversecretion of insulin) given additional insulin without a basic carbohydrate study. The result must be obvious. One such patient was given insulin daily by her physician before luncheon and allowed to leave his office and return to her home several blocks away. She had insulin shock and fainted in the street on two occasions. Her carbohydrate tolerance was found to be high.

After such a study, if there are no contraindications, insulin is indicated. Starting with four or five units, two or three times a day, a half-hour before meals, to test the individual susceptibility, the dose can usually be raised within a few days to ten or even fifteen units. We rarely go beyond ten. The patient is advised to eat always within a half-hour after taking the insulin, and to carry candy or lump sugar with him at all times. Hypoglycemic symptoms of a mild degree are frequent, but not alarming. Real shock is rarely encountered. The diet should be elevated, although this is usually spontaneous, from the increased appetite. Malnourished children are particularly responsive to this type of management, but the dose, of course, must be regulated according to age. The weight gain is slow. Approximately 50 per

cent of adults relapse to the former weight level some weeks after the insulin is withdrawn, but on the whole the treatment is definitely worth while.

### 3. *In the Treatment of Individuals Debilitated by Disease or Following Serious Operations.*

Everything that has been said under the previous heading pertains here as well. Special caution is necessary, however, since every disease entity and the physical status of each individual present a different therapeutic problem. Persons suffering from tuberculosis, the psychoses, narcotic addiction, the anemias, postinfectious processes, kidney, and other disorders, have benefited from the intelligent application of the insulin regimen. Of course, there is no specificity as regards any of these conditions, only the beneficent effect of an improved metabolism.

### 4. *In Diagnostic Procedures.*

It has been shown, by numerous observers, that persons suffering from Addison's disease, pituitary cachexia, and other hypoadrenal states and severe hypothyroidism, with or without myxedema, are particularly sensitive to insulin. The carbohydrate tolerance is frequently but not consistently elevated (low blood sugar). The reverse is true in hyperadrenia, active acromegaly, and other hyperactive pituitary states, particularly in toxic goiter. Many of these latter have diabetic blood-sugar curves. When the diagnosis is difficult, a not infrequent occurrence in debilitated individuals with a rather vague symptomatology, insulin is frequently a diagnostic tool of considerable value. No definite conclusions may, as yet, be drawn from an individual susceptibility or tolerance to insulin, but I have seen at least one borderline case of Addison's disease and one of pituitary cachexia (both later verified) in whom susceptibility to insulin gave early major diagnostic clues.

John of Cleveland has recently reported the treatment of an individual suffering from hyperinsulinism, in whom small doses of insulin before meals apparently rested the pancreas and retarded the natural insulin outflow. The treatment was attended by considerable clinical relief. This use of insulin, on account of its rather revolutionary and paradoxical nature, was not included in my original outline. Our recent work in giving sugar to underweight children one hour before meals in order to stimulate the production of insulin and thereby increase the appetite would tend to confirm John's observation in a roundabout way. At any rate, such a use of insulin must be considered.

In closing I wish to point out that occasionally one discovers an individual who is sensitive to insulin on an allergic basis. While this should be considered, it should not create undue apprehension. Persons are susceptible or unsuspceptible to insulin according to their make-up and individual biochemistry. No rule of thumb can be laid down as regards dosage in any type of person or disorder.\*

\* Part II of this symposium on "Endocrine Preparations and Their Clinical Usefulness" will be printed in the April issue of this journal.

### INGBER RESOLUTION NO. 2 \* X

WHEREAS, The studies of the Committee of Five of the California Medical Association have shown the inability of a certain percentage of our population to adequately finance the cost entailed by illness; and

WHEREAS, Because of this economic situation proper medical care is beyond the reach of this population group; and

WHEREAS, It has been established that this problem can be alleviated by the utilization of the insurance principle; now, therefore be it

*Resolved*, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital;
2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system;
3. There shall be no provision for cash benefits;
4. The patient shall receive adequate treatment and his physician shall receive adequate compensation;
5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended, or approved by the profession; and be it further

*Resolved*, That the California Medical Association immediately offer its full aid and coöperation to the Interim Committee of the Senate of the State of California charged with the study of this problem, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

*Resolved*, That there be formed a special committee authorized and empowered to act herein, constituted as follows: the Legislative Committee of the Association and three members of the Association to be appointed by the Speaker of the House.

*Susceptibility to Colds Varies.*—Are drafts likely to produce colds?

Yes, certainly in a susceptible individual. Here again it is a question of chilling of the body surface. A man can work all day in a strong, chilly wind, and if active and warmly clad, he will not catch cold; on the other hand, a person may be working quietly in a warm, still room with a constant draft of not very cold air on the back of the neck. In susceptible persons this may produce a cold.

Is it possible to harden oneself so that one does not feel the cold? Yes, certainly. Crippled children in chronic hospitals are trained to live outdoors, almost naked, winter and summer.

Many persons take cold baths to harden themselves against sudden changes in temperature. They feel perfectly sure that this method prevents them from catching cold. Cold baths are certainly stimulating, but it must be remembered that they are without benefit unless they are followed by a good reaction with flushing of the skin and a feeling of warmth.

Just as we have gone through the painful process of hardening our bodies against cold weather by gradual exposure to cold, sleeping on outdoor porches and taking cold baths, the skeptical scientist comes along and tells us that there is not the slightest evidence that any or all our efforts have the least effect in preventing us from catching cold.—Dr. Wilson G. Smillie, Professor of Public Health Administration, Harvard University School of Public Health.

\* Editor's Note.—This is Ingber resolution number 2 as revised and adopted by the California Medical Association House of Delegates on March 3, 1935. See also page 202 in this issue, for discussion thereon.

## California and Western Medicine

Official Organ of the California and Nevada Medical Associations

Owned and Published by the

**CALIFORNIA MEDICAL ASSOCIATION**

FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

Telephone Douglas 0062

Address editorial communications to Dr. George H. Kress as per above address; advertising and business communications to the Secretary-Treasurer, Dr. Frederick C. Warnshuis, also at the above address.

EDITOR . . . . . **GEORGE H. KRESS**

**Advertisements.**—The journal is published on the seventh of the month. Advertising copy must be received not later than the 15th of the month preceding issue. Advertising rates will be sent on request.

**BUSINESS MANAGER . FREDERICK C. WARNSHUIS**

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**A. GUTTMAN**, 1925 Wilshire Blvd., Los Angeles (VA 1221)

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Subscription prices, \$5.00 (\$6.00 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

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**Leaflet Regarding Rules of Publication.**—California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

## EDITORIALS\*

### IMPORTANT ACTION TAKEN BY THE C. M. A. HOUSE OF DELEGATES AT THE SPECIAL SESSION ON MARCH 2-3

*Action Taken by House May Mean Radical Changes in Practice in California.*—At the special session of the House of Delegates held at Los Angeles on Saturday and Sunday, March 2 and 3, policies were adopted which, should they be enacted into law by the California legislature, now in session, might radically change the form of medical practice in the Golden State. The House of Delegates at last year's annual session of the Association at Riverside authorized a medical economic survey of California, and recommended a special session of the House to consider the report of the survey committee, otherwise known as the Committee of Five. The Council issued the call for this meeting and designated the dates, as above, and the place as the headquarters building of the Los Angeles County Medical Association.

\*Editor's Note.—Copy for the March issue of CALIFORNIA AND WESTERN MEDICINE, inclusive of all editorials except the first on "Important Action Taken by the California Medical Association House of Delegates, at the Special Session, March 2 and 3," was sent to the printer on or before February 20, at least some ten days prior to the special session.

*The Members of the House of Delegates Were Alert to Their Responsibilities.*—We remember not a single meeting of the House of Delegates during the last twenty-five years, in which the presentation of viewpoints by delegates was made in such earnest, clarifying and courteous manner. Radical differences of opinion on the subject of sickness insurance were clearly in evidence from the first call to order, but all who spoke did so without the injection of personalities, the delegates listening with marked attention for one whole day before proceeding to vote on the different resolutions. All present seemed imbued with the tremendous seriousness and importance of the work before them, and of the heavy obligations they assumed for their five thousand fellows of the California Medical Association, on whose behalf and in whose name they were acting.

\* \* \*

*The Resolution Incorporating Major Recommendations.*—The resolution incorporating the major issues under special discussion was introduced by Dr. Irving Ingber of San Francisco and appears on page 187 of this issue of CALIFORNIA AND WESTERN MEDICINE, where it will be noted that the House of Delegates laid down certain principles to be included in any proposed sickness insurance legislation, designed to protect medical practice and standards. The responsibility of presenting the viewpoints of the Association to the Senate Interim Committee (Senator Dan E. Williams of Jamestown, chairman; Senator Edward H. Tickle of Carmel and Senator Leonard Joseph Difani of Riverside), was given over to a new committee of six members, consisting of the standing Committee on Public Policy and Legislation (Dr. Junius B. Harris, chairman, of Sacramento, Dr. Fred R. DeLappe of Modesto and Dr. E. T. Remmen of Glendale), and three additional members of the Association to be appointed by the Speaker of the House. Speaker Pallette later announced that he had so named Doctors Walter B. Coffey, T. Henshaw Kelly and Joseph Catton, all of San Francisco.

Before announcing the above appointments, Speaker Pallette received and gave careful consideration to many written and oral communications, and the committee as finally announced by him on March 9 was suggested by several of the strongest proponents of the Ingber resolution. It was pointed out that the committee should not only include members who had been much in favor of the action taken by the House of Delegates, but physicians whose affiliations at Sacramento would be of value in promoting the passage of legislation agreed upon, and who lived sufficiently near the Capital to make conferences possible and convenient.

It was also decided to appoint an advisory group to the Committee of Six whose members would be kept in touch with the work in hand, and who could be called upon for active aid, as required. On this advisory committee, up to the time this copy is sent to the printer, are the following:

Rodney A. Yoell,\* San Francisco; Clarence G. Toland, Los Angeles; Harry H. Wilson, Los Angeles; Robert A. Peers, Colfax; Dewey R. Powell, Stockton; Irving S. Ingber, San Francisco; R. Langley Porter, San Francisco; Loren R. Chandler, San Francisco; Frederick N. Scatena, Sacramento; LeRoy Brooks, San Francisco; Louis Albert Packard, Bakersfield; Henry Dietrich, Los Angeles; John Hunt Shephard, San Jose; A. J. Scott, Jr., Los Angeles; W. W. Roblee, Riverside; Lyell C. Kinney, San Diego; John H. Graves, San Francisco; and George Dawson, Napa.

\* \* \*

*Preliminary Reports of the Committee of Five.*—The Committee of Five, appointed after last year's Riverside Annual Session and consisting of Doctors William R. Molony, chairman, Los Angeles, Harry H. Wilson, secretary, Los Angeles, Alson R. Kilgore, San Francisco, Robert A. Peers, Colfax, and Rodney A. Yoell of San Francisco, brought in two preliminary reports, copies of which were sent in February to all delegates and component county societies. Much work is still to be done before the final report of the Committee of Five is completed, but it is hoped that it may be finished in time for consideration at the Yosemite Annual Session on May 13-16. In this issue we are printing, on page 160, for the information of members of the Association, some excerpts from the First Preliminary Report. This report was submitted to the Committee of Five by its Survey Staff (Paul A. Dodd, Ph. D., director).

\* \* \*

*Minutes of the Special Session Should be Read by Every C. M. A. Member.*—A perusal of the minutes of the special session of the House of Delegates, to be found on page 194, will reveal that the die has been cast. Prior to voting on the resolutions, the delegates virtually agreed that, regardless of personal beliefs, Association members should work as a unit, to attain the objectives adopted. Every member of the California Medical Association, therefore, should read carefully the digest of proceedings printed in this issue, because a clear understanding of what has been proposed, as the best solution at hand on the medical economic problems confronting the profession, is of the utmost importance. The Council voted that the March issue of CALIFORNIA AND WESTERN MEDICINE should be delivered to its readers two weeks later than its regular date of mailing, so that every member of the Association might be able to better visualize what had been done and is now before us.

\* \* \*

*Session Remarkable for Its Kindly Atmosphere.*—In bringing these comments to a close, the thought may be expressed that the headquarters building of the Los Angeles County Medical Association, with its quiet and restful atmosphere, was a real factor in promoting the amenities of courteous interchange of thought and fellowship.

\* Doctor Yoell who, on the Committee of Five, was most active in advocacy of the plan incorporated in the Ingber resolution, had declined membership on the Committee of Six, expressing himself, however, as being willing to serve on the advisory committee.

that were so much in evidence throughout the two-day session, as has been happily expressed in a resolution.

In conclusion, it is to be hoped that delegates from the county societies may use the reports\* in this issue as a basis for general discussion at early meetings of their respective groups.

#### A. M. A. HOUSE OF DELEGATES AND HEALTH INSURANCE

*The American Medical Association Special Session Report Is Printed in This Issue.*—On page 207 of this number of the official journal appears the complete report of the Reference Committee of the House of Delegates of the American Medical Association, as submitted at the special session which was held at Chicago on February 15 and 16.

As is well known, the American Medical Association House of Delegates is composed of representatives from each of the constituent state associations; the apportionment rules permitting, for example, the five thousand members of the California Medical Association to have seven delegates. In every particular, the House of Delegates of the American Medical Association may be stated to be composed of a group of physicians who are truly representative of the more than one hundred thousand medical men making up the membership of the national organization.

The House of Delegates was in special session for two full days, the business to be transacted being

"limited to the consideration of the social and economic policies of the Association, as related to pending and proposed legislation, to sickness insurance and to other matters which may be submitted by the Board of Trustees."

\* \* \*

*The American Medical Association Report Should Be Read by Every California Medical Association Member.*—The report of the Reference Committee was given by its chairman, Dr. Harry H. Wilson of Los Angeles, and is a pronouncement worthy of the careful thought and consideration of every member of the California Medical Association. Each of our representatives who went to the Chicago meeting put aside his personal professional work for more than a week in order, as a delegate from the California Medical Association, to render his bit of service to his fellows. Every other member of the California Medical Association should also do his bit by at least acquainting himself with the conclusions finally arrived at by our national body.

\* \* \*

*Special Session of the California Medical Association House of Delegates.*†—The House of Delegates of our own State Association will meet

\*Excerpts from the California survey, as given in the Preliminary Report, appear on page 160; resolutions of the House of Delegates of the American Medical Association on page 207; and minutes and resolutions of the special session of the House of Delegates of the California Medical Association, on pages 187 and 194.

†The call of the special session of the House of Delegates of the California Medical Association was printed on page 126 of the February issue. As previously stated, the March issue of CALIFORNIA AND WESTERN MEDICINE is brought off the press two weeks later than its regular mailing date to permit inclusion of the minutes of the special session of the House of Delegates of the California Medical Association.

at Los Angeles in special session on Saturday, March 2,

(a) to receive and consider the report of the Committee of Five, and to take such action thereon, and to formulate such principles and policies in regard to health insurance, medical services and medical care as the judgment and wisdom of the delegates may determine to be for the best interests of the public and the members of the Association;

(b) to transact such other business of the Association as may be transmitted to the House of Delegates by the Council of the Association.

If possible, the action taken on behalf of the California Medical Association by its own House of Delegates will also be printed in this issue.†

### YOSEMITE ANNUAL SESSION

*This Year's Annual Session from May 13 to 16.*—The attention of members is called to the fact that in about two short months the annual session, to be held May 13 to 16 at Yosemite National Park, will be upon us.

Because of the excellent scientific and other programs which are promised, and of the opportunity to see this wonderland of the national park service in a special setting of cordial, professional fellowship, every member of the California Medical Association who can conveniently arrange his work is urged to attend this year's meetings.

\* \* \*

*Interchange of Thought on Medical Problems Important.*—The exchange of viewpoints on some of the important economic and other problems which confront organized and scientific medicine is today much to be desired, in fact more than ever before. Keep in mind that the California Medical Association needs you and that you need the California Medical Association. At Yosemite these beneficial contacts can be most happily realized and appreciated. Elsewhere in this issue of CALIFORNIA AND WESTERN MEDICINE (on page 212) is a list of the hotels. Whether you go into the Yosemite Park by train and stage, or by automobile, it is advisable to make hotel reservations in ample time. Such coöperation will aid the hotel management in giving adequate service to all who attend. The complete scientific and other programs will be printed in next month's issue.

### PROPOSED PUBLIC HEALTH LEGISLATION

*List of Proposed Public Health Laws.*—On page 229 of CALIFORNIA AND WESTERN MEDICINE is printed a list of almost two hundred bills having to do, directly or indirectly, with public health laws of California, thirty-five having been submitted by State Senators and about one hundred and fifty by State Assemblymen. Brief comments indicate the nature of the proposed statutes. The perusal of the list is commended to all members of the California Medical Association be-

† Editor's Note.—The March issue of CALIFORNIA AND WESTERN MEDICINE is mailed later than usual in order to print proceedings of the special session of the House of Delegates, held at Los Angeles on March 2 and 3. See page 194 for these reports.

cause, in that way, the profession will better be able to appreciate the heavy labors in store for the Committee on Public Policy and Legislation (of which Dr. Junius B. Harris of Sacramento is chairman) and other officers.

\* \* \*

*Proposed Legislation Is of Importance to All Physicians.*—Any member who feels that such perusal might prove a waste of time may be reminded that some of the proposed laws have to do with compulsory health insurance, and that in their amended and final form (if they should go on to enactment) they would very considerably change the scientific and economic phases of medical practice. By now every alert member of the medical profession knows that in the national congress and also the legislatures of some forty states which will be in session this year, not one, but many measures are sure to be introduced which, should they become laws, would bring about radical departures from the established form of medical practice. However, at this time it is not our purpose to discuss the important subject of health (sickness) insurance in these columns, lest the editor's personal views be misunderstood and accepted as official statements from the Association or its officers. Until the Committee of Five (appointed through action of the House of Delegates at last year's Riverside annual session) brings in its report, and until the House of Delegates of the California Medical Association acts thereon, these editorial columns will call attention only to reports printed in this or other journals which may aid members of the Association to secure as broad a viewpoint as possible of different phases of the much-complicated health insurance problem.

\* \* \*

*The Hoffman Articles.*—In this connection, reference may be made to the series of contributed articles from the pen of Frederick L. Hoffman, which began in April, 1934, and now are brought to a close in the current issue.\* We understand that some criticism has been made concerning these papers, but to date the editor has received no communications in which specific attention is called to any errors or misstatements by Doctor Hoffman. Had such been received they would have been given publicity in regular manner in the Correspondence column. It may be proper, therefore, to state that the policy of CALIFORNIA AND WESTERN MEDICINE, as laid down by the Council, regarding contributed articles, has been posted for years at the editorial masthead and is expressed in the following language:

*Responsibility for Statements and Conclusions in Original Articles.*—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the JOURNAL and the demands on its space may permit. The right to reduce or reject any article is always reserved.

\*At the 230th meeting of the Council it was voted to complete the series of Hoffman articles on phases of sickness insurance (Item 11 on page 213).

*How Copies of Proposed Laws May Be Obtained.*—Every one of the almost two hundred proposed public health laws could be made the subject of special editorial comment, but lack of space prevents. Members desiring copies of particular bills can usually obtain them by addressing the State Printer, the Hon. Harry Hammond, State Printing Office, Sacramento. For the information of members, however, who are all supposed to be interested, reference will be made to a few of the bills offered for enactment.

\* \* \*

*Qualifying Certificate Act.*—This measure was introduced on January 26 as Assembly Bill 1552, by Assemblyman H. Dewey Anderson of Santa Clara County and James J. Boyle of Los Angeles County. Its general form was approved by the California Medical Association Council, and its provisions are practically the same as those previously outlined in this column. In its course through the committees, suggestions may be made for desirable amendments.

\* \* \*

*Clinic Law.*—This is Assembly Bill 1009, introduced by Assemblyman Roy J. Nielsen of Sacramento County, and recalls a draft of the law which, when first introduced two years ago, provoked a very severe fight in the legislature. The California State Board of Health was deputized to carry out the Act; but owing to some obscure provisions an opinion was sought from the State Attorney-General. One of his rulings made it impossible for the State Board of Health to do little more than compile a list of existing dispensaries in the State. In the opinion he gave, the Attorney-General ruled that no clinic should be obliged to pay more than \$5 annually; which would result in assessments so low that when totaled they could amount to only about \$600 per year, or a sum quite inadequate to cover the costs of worthwhile clinic inspection work. In the amended draft the annual fee is placed at \$20, making possible the creation of a fund with which some real work may be done in the future.

\* \* \*

*Bureau of Tuberculosis.*—In the August, 1934, issue of CALIFORNIA AND WESTERN MEDICINE, on page 118, Dr. W. P. Shepard referred to the California Tuberculosis Commission's report of 1915, in which was advocated a Bureau of Tuberculosis, together with a revolving State fund, to compensate counties which maintained satisfactory facilities for the care of the tuberculous sick. During the last twenty years, California's excellent record in tuberculosis work has led other states to adopt somewhat similar laws. In Assembly Bill 1928, introduced by Assemblyman Gene Flint of Los Angeles County, an amendment has been introduced which *deletes* from the law of 1915 the following vital language:

"provided, that the city, county, city and county, or group of counties shall not become entitled to receive such State aid unless the tuberculosis ward or hospital conforms to the regulations of and is approved by the State Bureau of Tuberculosis."

If this proposed amendment should become a law, it would throw the tuberculosis work of the State and counties into considerable disorder, and would lay the foundation for a "racket" whereby the yearly demands upon the State treasury could run into many thousands of dollars more than at any time in the last two decades; with a real deterioration, at the same time, in the service given to the tuberculous sick. It would be interesting to know who were the motivating forces back of this proposed and astonishing change in an already excellent and perfectly satisfactory law!\*

\* \* \*

*"Noxious Odors" Law.*—In Assembly Bill 2154, Assemblyman Harry B. Riley of Long Beach, Los Angeles County, proposes:

*"An Act to provide for the establishment and maintenance of a bureau in the State Board of Public Health for the suppression of noxious odors, prescribing its powers and duties, and making an appropriation to carry out the provisions hereof."*

It is to be assumed that this measure was introduced as a means of alleviating some of the unwholesome odors from the Signal Hill oil district; but it would place a heavy, and probably an impossible burden, upon the State Board of Health, which with its lessened budget of late has had to do its other and really important work upon little more than a skeleton basis.

\* \* \*

*Physicians and Hospital Records.*—Assembly Bill 2158, introduced by Assemblyman John G. Clark (an attorney by profession), also having a home address in Long Beach, Los Angeles County, is a short bill, but one so astounding in its provisions that it is here quoted in full. In view of the many court decisions on the inviolability of confidential relationships, not only for the medical but for the legal profession, it is difficult to understand how such a measure as the following could even have been seriously proposed:

*"An Act making it unlawful for hospitals, clinics, sanitariums, physicians, surgeons, or other persons to refuse inspection of records by attorneys."*

"The people of the State of California do enact as follows:

"Section 1. It shall be unlawful for any hospital, clinic, sanitarium, physician, surgeon, or other person or institution having in his or its possession records concerning the condition of health of any person made while said person was in the care of such person or institution, to fail or refuse to exhibit said records to any duly qualified and practicing attorney at law, desig-

\* Editor's Note.—Under the supervision of the Bureau of Tuberculosis, based on standards laid down by the California State Board of Health, the allocation of State funds for tuberculosis work runs into massive figures. Without such standardization and supervision and cross-check on claims of counties for reimbursement, the State's expenditures would be tremendously increased. The following figures should be of interest because they show the appropriations for subsidies, and the allotments made for the support of the Bureau of Tuberculosis, covering the last six years:

Fiscal Years	Allotments for Bureau Support	Appropriations for County Subsidies
Eighty-first and eighty-second (Ending June 30, 1931) .....	\$47,400.00	\$819,132.52
Eighty-third and eighty-fourth (Ending June 30, 1933) .....	44,040.00	1,043,155.52
Eighty-fifth and eighty-sixth (Ending June 30, 1935) .....	18,040.00	975,000.00

nated by said person in writing, and to allow copies of said records to be made, provided said inspection shall be made during reasonable business hours, and provided further that at the time of said inspection there shall be either pending or contemplated, litigation in which said records will, in the opinion of said attorney, be helpful to the cause of his client.

"Sec. 2. Violation of this section shall constitute a misdemeanor."

\* \* \*

**Nursing Survey.**—Senate Bill 417, introduced by Senator Thomas McCormack of Solano County, is "An Act authorizing a nursing survey to be made by the University of California, defining the powers and duties of the State Director of Finance in relation thereto, and making an appropriation therefor."

The measure would authorize the expenditure of not more than \$15,000 from the moneys that have been accumulating through license fees in the Nurses Registration Fund

"... to defray the expenses of making a survey of nursing conditions in the State of California, including the preparation and calculation of all data and facts concerning the education, training and employment of nurses, and the administration of the teaching of students preparing for nursing and public health service."

If the various nursing organizations in the State are willing that such a survey be made, it would seem that no objection should be raised.

\* \* \*

**The Heavy Responsibility of the Council and the Committee on Public Policy and Legislation.**—From what has been here written concerning a few of the many public health measures (on every one of which the Council of the California Medical Association must go on record as being either in favor of, against, or simply neutral) it becomes evident that much work will yet come before the profession up to the time the present (fifty-first) California Legislature adjourns (probably some time in May).

Meanwhile the interests of organized and scientific medicine will be under the constant supervision of the California Medical Association Committee on Public Policy and Legislation, the names of whose members may be found in the directory on page 2 of each issue of this official journal. If that committee, therefore, should call on members of the Association for aid, it is to be hoped that they will whole-heartedly give of their generous support, such as the committee's labors and important responsibilities at all times warrant.

#### SERA AND MEDICAL RELIEF

**Los Angeles County Medical Association Announces a Working Plan with the SERA.**—On page 227 of this issue of CALIFORNIA AND WESTERN MEDICINE is reprinted the announcement, recently sent to its members by the Los Angeles County Medical Association, concerning the arrangements which have been made with the officials of the State Emergency Relief Administration (SERA) to cover the medical care of the unemployed.

It is most gratifying to learn that in a large metropolitan center of California it was finally possible to come to some kind of working agree-

ment with the federal and state authorities who had in hand the relief of the unemployed. In one or two of the California counties having lesser populations, arrangements to compensate physicians for medical relief work rendered to the unemployed have been in operation for some months. In Los Angeles County, on several occasions in the past, the Los Angeles County Medical Association was prepared to put into operation plans that had been submitted, and that would have been satisfactory, but each time precipitate and unforeseen changes in the ever-shifting lay personnel of the federal and state emergency relief administrations brought the conferences and agreements to naught.

\* \* \*

**Medical Relief Is a Basic Need.**—In some states of the Union more or less satisfactory county arrangements have been in operation for a year or more. No legitimate reason can be brought forward against adding, to the other basic needs of food, clothing and shelter, that of medical relief to safeguard the health and lives of unemployed citizens. Nor can any sound argument be advanced or reasons be given why members of the medical profession should not be paid moderate fees for services so rendered, just as are their lay fellow citizens from whom the federal, state, and local governments purchase shelter, food and clothing for such unemployed persons.

\* \* \*

**Other Component County Societies Should Do Likewise.**—It is hoped that this cooperative effort on the part of a component county society of the California Medical Association, to offer its services and to act as the intermediate medical agent through which the services of all licensed physicians and surgeons who wish to participate in the relief work may be placed at the disposal of the local relief administration, will lead other county units to also work for similar agreements. As the plan stands, it is not limited to members of the county society, but is open to all licensed physicians and surgeons of reputable character.

The officers of the Los Angeles County Medical Association are to be congratulated on having brought to reality this agreement by means of which governmental and local agencies work hand in hand in medical relief for the unemployed. One additional thought: If the Los Angeles County Medical Association was able to successfully negotiate the difficulties involved in bringing its working agreement to a happy consummation, why should not all other component county medical societies in California initiate steps to bring about the adoption of similar agreements for their respective members?

\* \* \*

**Plan Keeps Medical Matters Under Control of the Medical Profession.**—One of the strong advantages of the Los Angeles plan is that it places the medical supervision and detailed professional work entirely in the hands of physicians, the governmental agencies looking to the county medical society to safeguard in proper manner the

joint interests of the State, the unemployed, and the medical profession. Also, it is an admirable way of trying out and learning to what extent the medical profession can give medical relief to low- or no-bracket income citizens, without the intervention of lay bureaucrats to tell physicians how they must perform their medical work. Whatever disciplinary supervision may be needed on matters medical, from the standpoints of both scientific and economic medicine, will be handled, not by lay supervisors, but by subcommittees of medical men appointed by the Los Angeles County Medical Association.

## EDITORIAL COMMENT\*

### THYROID THERAPY AND SCARS

The occurrence of hypertrophied scars and keloidal growths of the skin is of interest in all branches of medicine. The causation has been as obscure as the factors associated with the etiology of cancer.

Necessarily some trauma to the skin forms the background for the scar. The character of the resultant healing is a matter somewhat of conjecture. Previous perfect healing is of uncertain favorable prognostic value. A keloidal personal history, however, is markedly unfavorable, and a familial keloidal history is likely to prove an hereditary tendency. Pathologic examination of hypertrophied scar and keloidal tissue has disclosed little or no tangible difference from ordinary scar tissue.

Healing, *per se*, is of course influenced by the causative trauma, inflammation, infection, tension, suture material, antiseptics, pressure, etc. However, none of these have been found uniformly as the cause of permanent hypertrophied scar and keloidal involvement.

In June, 1933, in a paper read before the American Medical Association, the writer called attention to the interesting returns of a large number of minus basal metabolic readings in patients with hypertrophied scars and keloids. The fact that these patients improve with thyroid therapy has been a consolation to the surgeon. It is to be understood, however, that we have not reached Ehrlich's dream of a single dose of medicine correcting a condition at once, or anything like it.

A large percentage of our reconstructive plastic surgery cases with hypertrophied scars and keloids have benefited materially with one or two grains of thyroid substance, *per orem*, daily. Improvement is noticed within thirty to sixty days, but the medication may have to be carried on for an indefinite period. It is to be noted, in this type of patients who scar badly, that the glandular therapy also causes a marked improvement in the general physical and mental condition.

\* This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

The basal metabolic rate offers perhaps the only easy method of determining functional glandular measurement in a patient, and clinical symptoms and observations evaluate the glandular status in others.

The consensus of medical opinion seems to be that the ductless glands are more or less dependent on one another. In calling attention to thyroid insufficiency as a factor in poor skin healing, we must think, then, of the possibility of poor healing in all subglandular cases. Skin healing may also offer a picture of internal healing following trauma. The earlier this type of patient is recognized before surgery and treatment are instituted, the better our results will be.

6777 Hollywood Boulevard.

HOWARD L. UPDEGRAFF,  
Hollywood.

### TREATMENT OF MALIGNANT MELANOMAS

When one thinks of malignant melanomas, he is apt to look upon the victim as being doomed. Indeed, the five-year end results from a surgical standpoint are so depressing that such an attitude is probably justifiable. Thus, Broders and McCarty reported seventy cases in 1916, of which patients only 5.2 per cent lived for from four to eight years after surgical excision. Bloodgood reported 200 cases treated by surgery and the cautery, and only one lived five years. McCain saw six cases, and two lived five years after radiation alone. In a recent issue of *Acta Radiologica*,<sup>†</sup> Scharngel of New York City, who was studying at Radium Hammet in Stockholm, reports on eighty-one patients seen at that institution from January, 1921, to July, 1930. Here a technique of combined electrosurgery and radiation, either by radium or x-ray, has been evolved, which has resulted in a remarkably high percentage of five-year cures. Of the eighty-one patients seen, only seventy were actually treated; but by the technique they had evolved, 38.7 per cent were living over five years. Thirty-six of these patients had metastasis—nine living for three years, and four for five years. In view of these results, an extremely pessimistic viewpoint is not justifiable. Melanomas are very malignant, but by a combined electrosurgical and radiological technique many patients have almost a 40 per cent chance of a five-year survival.

These figures are very impressive, but represent a method of treatment which must be carried out with precision to accomplish such results. The electrosurgery is thorough, and the radiation therapy is pushed to the limit of tissue tolerance. The possession and use of a surgical diathermy unit and a fifty-milligram tube of radium in this condition is not enough; it requires experience in management and the use of massive amounts of radium up to two or three grams to accomplish the best results and to insure complete eradication and permanency of cure.

1407 South Hope Street.

ORVILLE N. MELAND,  
Los Angeles.

<sup>†</sup>Treatment of malignant melanomas of the skin and vulva. *Acta Radiologica*, Vol. XIV, No. 81, p. 473.

# MINUTES—SPECIAL SESSION OF HOUSE OF DELEGATES OF CALIFORNIA MEDICAL ASSOCIATION

## AT LOS ANGELES ON MARCH 2, 3, 1935

### OFFICIAL MINUTES, SPECIAL MEETING, HOUSE OF DELEGATES, CALIFORNIA MEDICAL ASSOCIATION

**Minutes of the Meeting of the First Day**  
**Saturday, March 2, 1935, 1 o'clock a. m.**

In response to the call issued by the Council, the House of Delegates of the California Medical Association convened in special session in the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, Los Angeles, California, on Saturday, March 2, 1935, at 1 p. m.

The meeting was called to order by Speaker Edward M. Palette.

The Speaker: The meeting will please come to order. The first order of business is the report of the Credentials Committee, Dr. Eric Larson, chairman.

The Speaker: You can report on the list as submitted.

Doctor Larson: Yes, we can approve the list that has been submitted and the delegates that have badges.

The Speaker: The secretary will call the roll. At this time, I would like to introduce to this House of Delegates Dr. Frederick C. Warnshuis, our new secretary. (Thereupon the secretary called the roll.)

#### REFERENCE COMMITTEES NOS. 1 AND 2

The Speaker: The secretary reports a quorum present. The Speaker at this time would like to announce an additional committee, a Reference Committee. We had appointed one Reference Committee, consisting of Dr. Philip K. Gilman of San Francisco as chairman, F. N. Scatena of Sacramento and Lowell S. Goin of Los Angeles. The Council has found that there will be so much work for this committee to do that we are going to limit their work to a consideration of the recommendations on the report of the Committee of Five, so that there will be an additional committee to consider other resolutions. This will be Reference Committee No. 2, Dr. Carl R. Howson of Los Angeles, chairman. L. R. Chandler of San Francisco and George H. Kress. The Speaker has appointed Dr. E. V. Askey as sergeant at arms.

#### EXECUTIVE SESSION

Doctor Clarke: I move that this House of Delegates go into executive session, and that only those who are accredited delegates and members of the California Medical Association be permitted to participate in this executive session.

The Speaker: Is there a second to this motion?

Doctor Kelly: I second it.

The Speaker: It is moved and seconded that we go into executive session, and that only members of the House of Delegates and members of the California Medical Association be admitted. Those in favor say aye. Those opposed say no. It is carried. The secretary will now read the call for the special meeting.

(Secretary reads call for special meeting.)

The Speaker: The House is now duly constituted and open for business under the call. The next order of business is the report of Doctor Molony.

Doctor Molony: Mr. Speaker, may we have the Supplement to the Preliminary Report submitted to the California Medical Association Committee of Five for the study of medical care?

I would like to have that report distributed to the delegates.

Mr. Speaker, and members of the House of Delegates of the California Medical Association: The Committee of Five appointed upon the authority of the House of Delegates at the meeting of the California Medical Association at Riverside in 1934, respectfully submits the following report.

#### REPORT OF COMMITTEE OF FIVE

I

March, 1, 1935.

#### *To the House of Delegates:*

(a) The Committee of Five, appointed under the authority of the House of Delegates at the meeting of the California Medical Association at Riverside in 1934, respectfully submit this report. The following resolution was adopted at the above-named meeting:

*Resolved*, That a committee be, and hereby is constituted, consisting of two members of the Council to be appointed by the chairman of the Council, and three members of the House of Delegates to be appointed by the Speaker of the House, whose duty shall be the consideration of health insurance.

*Resolved*, That this committee shall be instructed to conduct an adequate study and survey of the problem as it applies to California and to formulate a plan for the administration of health insurance and to prepare a bill for suitable legislation which may be available for presentation in the 1935 session of the California State Legislature.

*Resolved*, That the Council be, and is hereby instructed to appropriate funds sufficient to employ adequate and competent technical and legal assistance and advice for the purpose of this committee.

(b) The members of the Committee of Five are Doctors Robert A. Peers, Alson Kilgore, Rodney Yoell, Harry H. Wilson, and William R. Molony, Sr.

(c) The organization meeting was held in Los Angeles on June 2, 1934. At the meeting it was voted that the committee operate under the name of the California Medical Association Special Committee for the Study of Medical Care. Dr. William R. Molony, Sr., was elected chairman, and Dr. Harry H. Wilson was elected secretary. After many conferences the survey was organized, with Paul A. Dodd, Ph. D., as director of the survey. He is assistant professor of economics, University of California at Los Angeles, and Gordon S. Watkins, Ph. D., as supervising director, consulting economist, professor of economics, University of California at Los Angeles.

(d) An advisory council, consisting of the following, were named: John B. Canning, Ph. D., professor of economics, Stanford University; Arthur G. Coons, Ph. D., dean of men and associate professor economics, Occidental College; Rockwell D. Hunt, Ph. D., dean of the Graduate School, University of Southern California; the Reverend James J. Lyons, S. J., president of the University of Santa Clara; Samuel C. May, Ph. D., professor of political science, director of the Bureau of Public Administration, University of California.

(e) The director started the work of the organization of the survey on August 1, 1934. The first meeting of the committee was held on August 13, 1934, at which time the outline of the study was approved.

The possibility of securing aid for field and tabulation work from the Government through the SERA having been discussed, the first application for aid

from this source was made on August 25. It was only after many conferences with State and Federal authorities by Doctors Dodd and Wilson that the application was finally approved. The field work started in Orange County on October 3 and continued in Riverside County a week later. On the basis of a preliminary report to Washington of our organization set-up and our findings through the field work in Orange and Riverside counties, the Federal Government approved the project and authorized an appropriation for the work.

In order that the information called for in the survey might be representative of the whole State and of the different industries in the various parts thereof, the field work was done in twenty-six counties, representing the urban, suburban, farming distribution of the population, so that the field work, state-wide in extent, which began on October 3 in Orange County and extended from Humboldt County on the north to San Diego County on the south, was finally completed on January 16, 1935. The objective of the Survey was to ascertain from all available sources the information as to experience of the people of California as to sickness, together with all of the agencies concerned in the medical and hospital care. A questionnaire was sent to every physician and surgeon, osteopath, and dentist in the State. Considerable difficulty was experienced in obtaining the prompt cooperation from these groups, and repeated requests were necessary in order to obtain even a fair return.

3,600 complete returns were received from the physicians.

2,000 complete returns were received from the dentists.

800 complete returns were received from the osteopaths.

230 complete returns were received from the hospitals.

150 complete returns were received from the clinics.

24,000 completed questionnaires or schedules were obtained from families.

21,000 by the field worker, and 3,000 by mail from sparsely settled districts.

Since the completion of the field work, the tabulation of the results has been under way and, while good progress has been made in this regard, the director, Doctor Dodd, states that this phase of the work cannot be completed before May or June of this year. During December, 1934, January and February, 1935, the committee has had many meetings, contacting from time to time the Advisory Council, the Research staff, the Council of the California Medical Association, the Interim Committee of the State Senate, and other interested agencies.

By reason of the magnitude of the undertaking, the time-consuming task of proper tabulation of the results of the Survey, and the lack of time for a thorough digest of the information at hand, has made it very difficult for the Advisory Council, the Research staff, and the committee to make a comprehensive and deliberate study for the purpose of submitting a report which will adequately convey the real situation in California.

(f) When it was found necessary that a governmental agency must sponsor any project before Federal funds could be made available, the California State Department of Public Health gave their unqualified sponsorship to the project. The committee wishes to express their appreciation of this action.

(g) The Committee of Five desires to express its cordial appreciation of the spirit of cooperation in its work accorded by the Senate Interim Committee.

## II

(a) The committee has available as a part of this report a financial statement including an outline of the scope of work as accomplished and contemplated for final presentation when desired.

## CALIFORNIA MEDICAL-ECONOMIC SURVEY

### Financial Report

Expenditures—August 1, 1934 to March 1, 1935:

#### Salaries—

Full time staff—Administrative and office .....	\$7,042.76
Statisticians .....	1,697.66
Field supervisors and visitors .....	3,538.57
Professional coders, editors and machine operators.....	1,059.10
Part-time office help.....	695.43
District office expenses.....	\$14,033.52
Furniture rental .....	319.95
Machine rental .....	445.00
Office rental .....	489.56
Postage .....	373.51
Printing .....	2,382.04
Reports, books, etc.....	2,090.70
Office supplies .....	79.40
Telephone and telegraph.....	1,187.23
	594.19

#### Traveling expenses—

Meals .....	477.10
Hotels .....	512.50
Transportation (fare) .....	907.60
Postage .....	38.37
Telephone and telegraph .....	85.40
Tips .....	49.45
Supplies .....	41.43
Miscellaneous .....	203.42
Car expense .....	704.84
Maps and field supplies.....	3,020.11
	167.89

#### Contingent expenses—

(Insurance, freight, bonds, etc.) .....	232.17
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Total expenditure by California Medical Association..... \$25,415.36

#### SERA Government Appropriation—

Original .....	\$41,505.20
Supplement .....	13,920.22
*Total SERA Appropriation.....	55,425.42
	\$80,840.78

Total receipts from California Medical Association .....

Total expenditures—August 1, 1934 to March 1, 1935.....

Cash balance .....

Balance in bank, March 1, 1935.....

Petty cash fund on hand.....

Total cash balance .....

\$ 584.64

\*Note: Government appropriations include all grants necessary to finish survey work. About \$4,000 still remains to be used from these government grants. These appropriations were secured upon official request by the California State Board of Health.

(b and c) The preliminary report of the staff to the Committee of Five has been submitted to each member of the House of Delegates together with the supplementary report, which is now available. The correlation of the statistical data as gathered will be continued and when properly digested will be made available in the final report of the committee and the Survey staff on completion of the study.

(Exhibit B—Preliminary Report of survey.)

(Exhibit C—Supplementary Report of survey staff.)

## CONCLUSIONS

In order that the medical profession may continue to serve the people of the State in the prevention of disease, the maintenance of health and the curative care of illness, in a manner that will meet the apparent economic factors, and at the same time protect public welfare by safeguarding to the medical profession the functions of control of professional standards, the continued advancement of educational requirements and at the same time not destroy the initiative which is vital to the highest type of medical service,

The committee recommends that the House of Delegates adopt as its plan the furnishing of health service on a voluntary basis to the people of California on the plan and by the mechanism herewith outlined, rather than approve of the establishment of compulsory health insurance.

The proposal which has been adopted by the committee for recommendation to the House of Delegates is one primarily prepared for the committee by a subcommittee of one, and will be presented to the House of Delegates by this subcommittee.

In accordance with the instructions of the House of Delegates in constituting the Committee of Five, a health insurance bill was submitted to the House of Delegates. The majority of the committee believe that compulsion as embodied in the compulsory health insurance bill is incompatible with adequate medical care to the greatest number of people in the State of California; therefore, though fulfilling the instructions that a bill be drafted which may be available, the committee recommends that it be not adopted as representing the policy of the California Medical Association.

The bill was primarily drawn by a subcommittee of one, and will be presented to the House of Delegates as a part of a minority report by this committee.

Respectfully submitted,

WILLIAM R. MOLONY, *Chairman*

ALSON KILGORE

ROBERT PEERS

HARRY H. WILSON

Minority: Rodney Yoell.

Doctor Molony: You have had sent to you the Preliminary Report, the large bound volume, on January 16, or some time after that, and today you have the Supplementary Report of the work completed to date. This is respectfully submitted and signed William R. Molony, Alson Kilgore, Robert Peers, Harry H. Wilson. I think it would be advisable at this time for Doctor Kilgore to present to the House a Committee of One's report as far as voluntary insurance is concerned.

The Speaker: Doctor Kilgore.

Doctor Kilgore: Mr. Speaker and members of the House: It is my understanding that it is not in order at this time to introduce argument. I shall confine myself, therefore, to presenting the report of the Committee of One to the Committee of Five, which has been made a part of the report of the Committee of Five, with instructions and explanatory comments. This has been presented through the mails to all the delegates in the form of a mimeographed set of sheets headed here "Proposed Declaration of Purpose by the California Medical Association." Mr. Speaker, does the House desire that I shall read this all. Each and every one here has a copy.

(Report presented.)

#### REPORT AND RESOLUTION OF DOCTOR KILGORE ON A PLAN OF VOLUNTARY INSURANCE

##### To the House of Delegates:

This report as submitted consists of: (1) a preamble; (2) an outline of a plan; (3) a resolution embodying the principles of a voluntary health insurance plan to be considered by the California Medical Association.

Your committee recommends that the report be amended to delete x-ray, laboratory and anesthesia from the hospital services.

If the House of Delegates adopt the principles contained in this report as amended, the House of Delegates should not commit itself to the detached provisions of the specific plan (Part 2 of the report), but should have the Council or other delegated body free to modify details after conference with all other interests involved, and to adopt and support any plan of voluntary service consistent with said principles.

##### PREAMBLE

The medical profession of California recognizes that inevitably increasing costs of good medical care

coupled with an increasing percentage of population in low income groups has presented a growing social problem. We have earnestly sought methods of meeting this problem and have been forced to conclude that it can be met only by spreading the costs of the illnesses of the few among the many subject to the risk, *i. e.*, by health insurance.

The California Medical Association further recognizes that not only should health insurance be made available but that, for the final solution of the social problem involved, the system may very well have to be a compulsory one, for the very obvious reason that under a strictly voluntary system some individuals who most need protection will not accept and pay for it.

The profession clearly recognizes grave dangers and faults of health insurance, some inherent in the system itself, others avoidable or at least minimizable by careful planning on a basis of practical experience. Among these dangers are:

(1) Interference by an administrative machinery between patients and their physicians.

(2) Development of political control and a bureaucracy of supervision, sapping funds which should be used for the care of the sick and degrading medicine and medical service.

(3) Diversion of time and energy to the red tape of "paper work" and to the prevention of malingering—time and energy which should be spent only in medical service to the sick.

Recognizing these and many other dangers, the California Medical Association appreciates its obligation to the people of the State to plan and conduct this branch of health service to the community in such form and manner as to preserve (in so far as is humanly possible) the highest standards of service of physicians to the community. We must see to it that health insurance is organized and operated so that its evils will be minimized and its advantages best utilized for the people.

The California Medical Association is cognizant not only of the above dangers but also of the difficulty and complexity of the problems of organization and administration of a system suitable for America. The people of California would, and should not, be satisfied with health insurance furnishing, as in the British system, only office and home treatment, leaving them to the mercy of charity when special services and hospital care are required. The experience of foreign systems will not furnish solutions to all the intricate and complex relationships of consulting services in all the specialties, to say nothing of hospital care.

At the present time the California Medical Association believes that no one can be sure of the best answers to many of the problems involved and that no amount of theoretical debate will suffice. We believe that these problems should be worked out in the school of practical experience before the provisions are incorporated into law, because any initial legislative error might well prove costly and disastrous.

We believe that with experience first in the actual practical operation of health insurance on a voluntary basis, we shall arrive sooner at a more satisfactory compulsory system than if attempt is made to write the final law today.

The California Medical Association, therefore, proposes to set up, on its own responsibility with the coöperation of hospitals and other interested groups, and offer to the people of California a health insurance service and to this end has adopted the following resolution of instructions to its Council.

##### RESOLUTION

WHEREAS, The California Medical Association recognizes that the costs of illness and the attendant medical, dental and hospital care are now unevenly distributed and constitute a grave financial hazard to those of moderate and low incomes; and

WHEREAS, The California Medical Association also recognizes that, on account of this very financial haz-

ard, many individuals faced with serious illness must often choose between charity and inadequate care; and

WHEREAS, After nine months' study and the expenditure of a large sum of money with the coöperation and financial support of the Federal and State governments, it has become apparent that the only practical solution to this problem at present available is the utilization of the insurance principle; and

WHEREAS, The California Medical Association believes that arrangements should be made whereby those of moderate and low incomes may provide against these financial hazards by the utilization of this principle of insurance; and

WHEREAS, The California Medical Association believes that, since it constitutes the organized medical profession of this State, an effort to solve the problem of providing ways and means for the above purposes constitutes a part of its obligation to the people of California; now, therefore, be it

*Resolved,*

(1) That the California Medical Association establish an organization for the specific purpose of providing means whereby the costs of care in sickness and injury for those of moderate and low incomes may be met by the method of periodic payments in advance.

(2) That this organization shall contemplate providing for meeting costs of both professional services and hospital care.

(3) That the Council be and is hereby instructed to perfect a plan of organization, scope of service and rules of operation for the purposes herein set forth, and that the Council be and is hereby instructed to set it up and cause it to be put into operation as soon, and for such scope of service, as may be found lawful and practical, specifically having in mind that, whatever initial scope of service and operation may be determined upon, it is the eventual purpose of the California Medical Association to make the use of this contemplated organization available to all citizens of the State (within certain income limits) for provision against costs of both complete professional service (including specialists' services, surgical operation, dental care as it relates to the eradication of infection) and hospital care.

(4) That, in the plan of organization and rules of operation, the following provisions shall be adhered to:

(a) Both financial and administrative responsibility shall be assumed by the organized medical profession through such organization.

(b) Free choice of physician, dentist and hospital by patient shall be maintained.

(c) Practice under the plan shall be open to reputable physicians and dentists, regardless of membership in the California Medical Association or the State Dental associations.

(d) In so far as is humanly possible in the conduct of any plan of collective financial action, the traditional private patient-private physician relationship shall be maintained.

(e) Compensation to physicians shall be on a basis of services rendered.

(f) Compensation to physicians shall be paid only for services personally rendered (except that special permission may be given physicians to have bona fide assistants associated with them in furnishing services).

(g) Arrangements for provision of dental care contemplated shall be made by and with the State Dental Associations.

(h) The plan shall be operated without profit to anyone.

(5) That the Council be and is hereby instructed to appropriate such sums of money as may be necessary to the accomplishment of the purposes of this resolution, and in addition to assess (or levy) such amount of per capita contribution by physicians and dentists desiring to care for patients under the arrangements contemplated as may be deemed necessary for organization and institution of operations.

(6) That the Council be and is hereby instructed to take steps toward securing any and/or such legal enactments as may be necessary for the lawful carrying out of the purposes of this resolution.

Respectfully submitted,

ALSON KILGORE.

\* \* \*

The Speaker: These reports will be referred to Reference Committee No. 1. Any other report from the Committee of Five? Have you any report, Doctor Yoell?

Doctor Yoell: Mr. Chairman and fellow members of the House of Delegates of the California Medical Association. This is a minority report of the Committee of Five to the Council of the California Medical Association, pursuant to the instructions passed by the House of Delegates at its last meeting.

(Report read.)

**REPORT OF DOCTOR YOELL ON A PLAN OF  
COMPULSORY SICKNESS INSURANCE**

*To the House of Delegates:*

Your committee has carefully and at great length considered the problem under discussion. We are of the opinion that the present system of medical practice is not satisfactory inasmuch as the people are not receiving nor can they receive proper medical care, as it now functions.

This situation is directly traceable to the undoubted inability of a large majority of the population to finance on an individual basis the essential cost of health service.

It seems logical, therefore, that the insurance principle be applied as a method of accomplishing by coöperation that which cannot be accomplished individually.

Our studies have shown that it is the almost universal experience in civilized countries which have tried the insurance principle that such application must be compulsory to be effective and we, therefore, recommend that the House of Delegates of the California Medical Association endorse the principle of compulsory health insurance and ask at this session of the legislature the enactment of such statutes as will carry it into operation.

We further consider and are of the opinion that only by this method will proper medical service be secured to the people, and only under this method can the medical profession survive in an independent rôle. It is not a question of voluntary insurance versus compulsory insurance; viewing the political scene we feel it is either insurance or some form of state medicine.

The following minority report of the Committee of Five is offered pursuant to your instructions. A plan is submitted for a system of compulsory health insurance and a bill is offered in support of the plan, which coördinates much legal and technical opinion. We suggest that the principles embraced in the plan and the bill be the basis of discussion with the Senate Interim Committee as representative of the opinion of organized medicine.

The final draft of the bill should contain a change in the composition of the commission. We endorse the proposal of the Advisory Committee that the commission should consist of five members, at least two of whom must be physicians; that three names for each commissionership should be submitted to the Governor by the Board of Regents of the University of California.

We suggest the elimination of certain recognized religious sects from the provisions of the act be considered.

We recommend the elimination of Section 33, page 26, and we recommend that no provision be made for contribution to the fund by the State.

Respectfully submitted,

RODNEY YOELL.

The Speaker: This report will be referred to the committee.

The next order of business is communications from the Council. Dr. T. H. Kelly.

#### COMMUNICATION FROM THE COUNCIL

Doctor Kelly: Mr. Speaker and members of the House of Delegates of the California Medical Association: The Council has called this House into session to consider the report of the special Committee of Five upon health insurance in California and such other matters as the Council may present to you. The report of the special committee you have heard from that committee. The Council desires to recommend to you that in the consideration of this report, you exercise the greatest care and thought. The Council believes that the House of Delegates should, in its action upon this report, decide the following questions:

1. Is the House in favor of the continuation of the present forms of medical practice in California?
2. Is the House in favor of a state-wide plan of voluntary medical and hospital insurance under the California Medical Association, and with the necessary enabling legislation to put it into effect?
3. Is the House in favor of a compulsory plan of health insurance, and if so, by legislative enactment or by initiative or constitutional amendment, and with what minimum provisions for medical administration of medical care?
4. If the House favors a voluntary plan, does it wish to formulate minimum standards of medical administration for a compulsory plan if the same should later come into being?
5. If the House favors compulsion, does it wish to authorize a voluntary plan to be put into effect by the California Medical Association in the event—a possible one—that compulsory health insurance fails to pass this legislature?

6. In the event that the House favors no change in the present forms of medical practice, is it in favor of the development and extension of hospital insurance plans fostered or controlled by the hospitals of California or by organized medicine?

The Council urges that these questions be answered, in order that it may have the authority to proceed according to the best interests of medicine and public health, regardless of what adverse action any determination of the policy by this House may meet in the immediate future.

Further, the Council urges that the House express itself upon the matter of county hospitals, the corporate practice of medicine and compensation for medical services rendered to those on relief. An attempt is being made to open up county hospitals to all residents regardless of their economic status, and this House, in the opinion of the Council, should go on record against the forces seeking to thus undermine the practice of medicine, and to introduce the worst form of State medicine that we could have. Corporations seeking to promote their ends are ever attempting to encroach farther into the practice of medicine, and the House should express itself upon this matter.

Finally, because of causes beyond the control of medicine in California, there has been a complete failure to develop any coordinated plan of medical care under the relief program in California. Medicine has been called on to care for all of those needing it, and little has been returned to those physicians giving, thus, of their time and skill. The House should urge both the Federal and State Emergency Relief Administrations to rapidly develop and put into operation a plan for medical care of those on relief in California, the plan to be worked out in conjunction with organized medicine, as stated by the rules and regulations No. 7 of the FERA.

The Council wishes to introduce, through its chairman, three resolutions that deal with those last three matters in the report, and they are introduced to put the question on the floor of the House. The House can do anything it wants with them. (See Reference Committee No. 2 report on resolutions presented.)

The Speaker: This communication and the other resolutions are referred to the Reference Committee

No. 2, of which Doctor Howson is chairman. Other resolutions from the floor are now in order.

#### RESOLUTIONS FROM THE FLOOR

Doctor Ingber: In order to bring this matter properly before the House of Delegates, I have two resolutions here from the members of the San Francisco delegation.

The Speaker: Will you read them, please?

Doctor Ingber: Resolution No. 1. (Reads Resolution No. 1.) (See Reference Committee report.)

Resolution No. 2. (Reads Resolution No. 2.) (See Reference Committee report.)

The Speaker: These resolutions will be referred to Reference Committee No. 2. Are there any other resolutions?

Doctor Anderson: Mr. Speaker and House of Delegates: (See Reference Committee report.)

The Speaker: This resolution will be referred to Reference Committee No. 1. Any other resolutions?

Doctor Scott: (Reads resolution.) (See Reference Committee report.)

The Speaker: This resolution will also go to Reference Committee No. 1. Any other resolutions?

#### INFORMAL DISCUSSION

Now, this completes our docket for today. We can do one of several things.

According to the docket, we will adjourn until ten o'clock tomorrow morning. However, we can do this, if you so desire, we can have an evening session. These committees can adjourn at this time and get busy, and report back here probably at eight o'clock tonight, because the big part of this meeting is a discussion of these resolutions. We may get through by working all day tomorrow, and we may not. That depends on how much there is to be done, and so it has been suggested that an evening session might shorten the work tomorrow a great deal. Is it desired to have an evening session?

Doctor Wilson: It will be difficult for your Reference Committee to listen to discussions this afternoon and bring in any sort of constructive report by eight o'clock tonight. I don't think we can.

Doctor Molony: As a matter of fact, there is nothing before the House until the Reference Committees Nos. 1 and 2 have made their reports.

Doctor Ingber: May I make a motion to recess until tomorrow morning?

A Doctor: I second it.

The Speaker: The substitute motion is that we recess until tomorrow morning. Are there any remarks?

Doctor Crosby: I think that the Reference Committees ought to tell us whether they want to present anything to us tonight, and I think we ought not to put up recessing until tomorrow morning until we have an expression of opinion from the Reference Committees.

The Speaker: Doctor Gilman.

Doctor Gilman: It will be very difficult to have a complete report by eight o'clock tonight and have it in good shape to present to this society.

The Speaker: Doctor Howson.

Doctor Howson: I think Reference Committee No. 2 will probably be able to report by eight o'clock this evening.

The Speaker: We could take up No. 2 first. They are separate questions. If we could adjourn until this evening and have a report from Committee No. 2 and act upon it.

Doctor Kerr: I should like to ask if it would not be possible to have a discussion this afternoon. The committees would have today and all night if they chose to discuss the matters, and recess then until tomorrow morning.

The Speaker: Well, that might be enlightening to the committees. The committees are open for discussion at all times. Different members do go before the committees and discuss, and we could have this discussion open this afternoon, if you want to do it. The question now is that we can adjourn now until tomorrow morning, or when we adjourn, adjourn until tomorrow morning.

The Speaker: Those who are in favor of having an evening session will please stand. Now, those who are opposed to an evening session will please stand.

The Secretary: Mr. Speaker, 77 yes, 24 no.

The Speaker: The motion prevails. This motion would change the docket as given by the Council, and so it requires a two-thirds vote, and we will have the evening session. The motion is carried.

Doctor Wilson: Mr. Speaker, is it in order to make a suggestion? It would seem rather desirable, in view of the discussion, to have an open discussion tonight, and then let the committee retire tonight and have the resolutions submitted and the value of the discussions, and then make the reports in the morning.

Doctor Kress: They might bring in a report covering the consensus of the report.

The Speaker: You have already voted to have an evening session.

Doctor Kress: I move, Mr. Chairman, that we proceed with an informal discussion by this House of Delegates at this time.

Doctor Reiss: I second that.

The Speaker: It is moved by Doctor Kress, and seconded by Doctor Reiss, that we continue with an informal discussion. These committees, if they wish, can adjourn or stay here and get ideas. Are there any remarks? Those in favor, say aye. Opposed, no. Carried. The floor is now open to anyone who wishes to make a speech. I have an announcement to make. There will be a dinner at six o'clock, upstairs. All delegates are invited as guests of the Los Angeles County Medical Association.

A general discussion was then engaged in by Delegates Powell, Hale, Yoell, Crosby, Shepherd, Ullmann, Burns, and Ruddock.

Doctor Howson presented the following resolution:

WHEREAS, The organized medical profession of the State of California fully recognizes the difficulties and problems faced by those of its citizens having incomes below or near the subsistence level when confronted by the necessity of making provision for serious illnesses; and

WHEREAS, We not only view sympathetically any attempts to make it possible for such citizens and their families to meet such problems, and for several years we have been making intensive studies with a view to finding a solution which shall be a true solution and not merely an alternative resulting in more serious difficulties and in inferior medical services; and

WHEREAS, It is well known that the type of medical care received by the American people is, on the average, much superior to that of any other country; and

WHEREAS, Because of this and because also of the much greater individualism which is an integral part of our heritage, it is our belief that none of the systems of compulsory health insurance in effect in any other country is applicable to conditions here or furnishes any reliable criterion upon which to base such a system for the country or State; and

WHEREAS, Careful study of the problem quickly reveals innumerable difficulties inherent in any attempt to transplant or adopt any European system to the conditions existing here; and

WHEREAS, Improperly conceived plans have and will inevitably result in deterioration of the quality of the medical care supplied to the insured; and

WHEREAS, Experience has shown that the widely varying conditions found in different localities result in plans which may be satisfactory in one section, proving utterly unsuitable for another district; and

WHEREAS, For these reasons the medical profession is attempting to learn the difficulties inherent in any plan aiming at a solution of this problem, and there are now in effect over 150 different schemes in localities scattered over the entire country; and

WHEREAS, We believe it would be definitely detrimental to the public interest were measures for compulsory health insurance placed upon the statute books at this time; and

WHEREAS, We further believe that in view of the experiments now being conducted by the medical profession which have brought to light many serious difficulties which could not have been foreseen, the solution of which can be found only by experience, that further time should be permitted them to arrive at a solution of the entire problem which shall be free from the defects inherent in all plans heretofore in effect, and which must inevitably creep into any plan which is based upon purely theoretical considerations, which are all that are available as yet; now therefore be it

Resolved, That it is the opinion of the House of Delegates of the California Medical Association that no legislation for compulsory health insurance should be passed at the 1935 session of the legislature.

A Member: I move that we adjourn until 8 o'clock.

Another Member: I second the motion.

The Speaker: I have been requested to say that there is a Publicity Committee which will contact the newspapers, and it is requested that the members do not talk to reporters.

Doctor Wilson: A motion to adjourn takes precedence, but today we agreed to meet tonight at 8 o'clock. I doubt seriously if Reference Committee No. 2 that has been sitting here in the discussions this afternoon, and from the progress that Committee No. 1 is making they will be able to make a comprehensive report tonight, and in view of the fact that a general discussion has been made available this afternoon, I will move for a reconsideration of the question as to when we should meet again.

A Doctor: I second the motion.

The Speaker: If there is no objection, we will put the motion. It is moved and seconded that we reconsider the motion whereby we agreed to have an evening session. Any remarks? Those in favor say aye. Opposed, no. Carried.

Doctor Wilson: I move that the House meet tomorrow morning as previously scheduled at 10 o'clock.

Doctor Powell: I second the motion.

Voices: Make it 9 o'clock.

Doctor Powell: Nine o'clock will be all right.

The Speaker: It is moved that when we adjourn we meet at 9 o'clock tomorrow morning. Is there a second?

Doctor Powell: Yes.

The Speaker: Are there any remarks?

Doctor Kelly: Just one moment, please. I am speaking for the secretary who has this unusual California voice that he apologized for. The Council voted to pay the railroad fare and the lower Pullman berth both ways of all delegates who had to buy railroad tickets and lower Pullman, and if you will send a statement of your expense to the secretary, or leave it with him during the session here, as soon as we get back to San Francisco checks will be mailed to you. If you drove your automobile you will be paid your railroad fare from where you came, and we will find out what the railroad fare would have been and send an equivalent check.

(Thereupon an adjournment was taken for the day.)

**Minutes of the Meeting of the Second Day****Sunday, March 3, 1935, 9 o'clock a. m.**

The Speaker: We will now listen to the roll call.

The Secretary: Mr. Speaker, your secretary holds in his hand the signed attendance slips of ninety-four delegates, and recommends that some delegate move that these attendance slips and those presented later constitute the roll call of this second session of this special session.

Doctor Chandler: I so move.

Doctor Reiss: I second the motion.

The Speaker: It is moved and seconded that this be the roll call. All those in favor say aye. Those opposed, no. Carried.

Now, gentlemen, we are ready for the report of the two reference committees, and it has been suggested that we handle it in this way, that the Reference Committee No. 1 read its report, with its recommendations, and then Reference Committee No. 2 read its report, with its recommendations. In that way you will get a picture of the whole thing, not one side without the other, and then we will go back and take up the recommendations of Committee No. 1 and pass on them. Is there any objection to that way of considering it? If not, Doctor Gilman will read the report of Reference Committee No. 1, with the recommendations of the committee thereon.

**REPORT OF REFERENCE COMMITTEE No. 1**

Doctor Gilman: Mr. Speaker and members of the House of Delegates: Your Reference Committee in taking up the resolution submitted by Doctor Scott—do you wish that resolution read? It is recommended at the suggestion of the author that it be withdrawn.

The Speaker: There is no objection?

**RESOLUTION NO. 1, INTRODUCED BY DR. INGBER**

Doctor Gilman: In respect to Resolution No. 1 introduced by Irving Ingber of San Francisco, this resolution your committee renders no report on, by consent of its author. Do you wish it read?

The Speaker: Will you read it, Doctor, please?

(Said resolution read.)

Doctor Ingber: That is not the resolution, sir. Here is the copy of the resolution that was handed to me and that was asked to be withdrawn.

Doctor Gilman: I have said that was my recommendation, sir, to withdraw this resolution, and some one requested to have it read.

Doctor Ingber: I thought it was withdrawn. Pardon me, sir.

Doctor Gilman: Repeating it, then, we rendered no report on this, at the request of the author.

The Speaker: If there is no objection, this will be considered withdrawn.

Doctor Gilman: Report of the Committee of Five. (Report read.)

The Speaker: No action will be taken at this time.

**RESOLUTION AND REPORT OF THE COMMITTEE OF ONE (DR. KILGORE) ON A PLAN FOR VOLUNTARY INSURANCE**

Doctor Gilman: Report and resolution of the Committee of One for voluntary health insurance, which is presented in the majority report of the Committee of Five. This report as submitted consists of one, a preamble, and two, an outline of the plan; three, a resolution embodying the principles of voluntary health insurance to be considered by the California Medical Association.

Doctor Gilman: The minority report of the Committee of Five.

(Report read.)

**RESOLUTION OFFERED BY DOCTOR HOWSON**

Doctor Gilman: The resolution submitted by Doctor Howson.

(Resolution read.)

Doctor Gilman: Council recommendations. These were referred to the No. 2 Committee, and by that committee referred, in part, back to Committee No. 1. (Resolution read.)

**RESOLUTION NO. 2, INTRODUCED BY DOCTOR INGBER**

Doctor Gilman: Finally, Resolution No. 2, introduced by Dr. Irving Ingber of San Francisco. The resolution reads:

(Resolution read.)

Doctor Gilman: That is the original resolution as introduced. Your committee has amended this resolution to read as follows:

(Resolution read.)

Doctor Gilman: Your committee recommends amending the above amended resolution to read as follows:

(Resolution read.)

Deleting the word "mandatory" as to certain population groups and "voluntary" as to certain population groups.

**REPORT OF REFERENCE COMMITTEE No. 2**

The Speaker: We will now ask the chairman of Reference Committee No. 2, to read the report of that committee.

Doctor Howson: Mr. Speaker and members of the House: Your Reference Committee No. 2 reports as follows:

(Reads report.)

Doctor Howson: I may say that the amendments made by the committee were matters of phraseology only.

**COUNCIL RESOLUTION B**

Council Resolution B, as amended.

(Reads resolution.)

Your committee recommends that this do pass.

**COUNCIL RESOLUTION C**

Council Resolution C.

(Reads resolution.)

Your committee recommends that this do pass.

**RESOLUTION INTRODUCED BY DR. ANDERSON**

Resolution presented by Dr. C. Max Anderson, as amended.

(Resolution read.)

This has been submitted without recommendation.

The second portion of the resolution submitted by Doctor Anderson now incorporated in a separate resolution reads as follows:

(Resolution read.)

This resolution is submitted without recommendation.

**ACTION OF HOUSE ON COMMITTEE REPORTS**

The Speaker: We will now take up the different recommendations of these two committees for action.

Doctor Gilman: Mr. Speaker: Your Committee No. 1 would like to introduce a further resolution, an emergency resolution, which was unavoidably delayed in being typewritten this morning, if such is possible.

The Speaker: If there is no objection we will hear the resolution and consider it.

Doctor Gilman: (Reads resolution.)

The Speaker: I think this would properly come from the Reference Committee No. 2, and I think it probably should be considered last, and if there is no objection we will consider it last. We had better have these all re-read, so we will know what we are acting upon. Please read the first recommendation.

Doctor Gilman: \* \* \*

**REPORT OF COMMITTEE OF FIVE**

WHEREAS, After the expenditure of eight months' time and a large sum of money, with the coöperation and financial support of the Federal and State governments, in a study of the problem of adequate medical care for the people of California, the Committee of Five has rendered the attached report; and

WHEREAS, The report represents a most valuable and comprehensive contribution; therefore be it

*Resolved*, That the Committee of Five be assured of the gratitude and appreciation of the California Medical Association.

Your Reference Committee recommends the adoption of this report and this resolution.

F. N. SCATENA  
C. G. GOIN  
P. L. GILMAN

Doctor Gilman: I recommend the adoption of this resolution as amended.

The Speaker: Is there a motion?

Doctor Crosby: I move its adoption.

Doctor Kerr: I second it.

The Speaker: It is moved by Doctor Crosby and seconded by Doctor Kerr that this resolution be adopted. Are there any remarks? Those in favor say aye. Those opposed, say no. It is carried.

\* \* \*

Doctor Gilman: Report and resolution of the Committee of One for voluntary health insurance.

REPORT AND RESOLUTION OF THE COMMITTEE OF ONE FOR  
VOLUNTARY INSURANCE (PRESENTED IN THE MAJORITY  
REPORT OF THE COMMITTEE OF FIVE)

This report as submitted consists of:

1. A preamble;
2. An outline of a plan;
3. A resolution embodying the principles of a voluntary health insurance plan to be considered by the California Medical Association.

Your committee recommends that the report be amended to delete x-ray, laboratory, and anesthesia from the hospital services. If the House of Delegates adopt the principle contained in this report as amended, the House of Delegates should not commit itself to the detailed provisions of the specific plan (Part II of the report), but should have the Council or other delegated body free to modify details after conference with all other interests involved, and to adopt and support any plan of voluntary service consistent with said principles.

Your Reference Committee recommends the combination of the preamble and resolution submitted with another resolution at this time.

F. N. SCATENA  
P. K. GILMAN  
LOWELL S. GOIN

That is the recommendation of your committee, and the one to which we have referred in the reading of this report of the Committee of One for compulsory insurance.

\* \* \*

Doctor Chandler: I arise to a point of information only. In voting on these resolutions, are we to be governed by a two-thirds majority or a bare 51 per cent?

The Speaker: Fifty-one per cent.

Doctor Chandler: I move that we adopt no resolution except by a two-thirds majority in favor of it.

The Speaker: Is there a second?

Doctor Scott: I second it.

The Speaker: It is moved by Doctor Chandler and seconded by Doctor Scott that a two-thirds majority be required to adopt any of these resolutions.

The Speaker: It has been moved and seconded that a two-thirds majority vote be required to adopt any of these resolutions. Those of you in favor will say aye. Opposed, no. The Chair is unable to determine. Those in favor will please rise and remain standing.

The Secretary: Forty.

The Speaker: Those opposed will please rise and remain standing.

The Secretary: There are sufficient rising to defeat it.

The Speaker: The motion is lost.

\* \* \*

The Speaker: Now, gentlemen, a motion is in order in regard to the adoption of the resolution just read.

Doctor Gilman: The chairman of Reference Committee No. 1 moves the adoption of this resolution.

The Speaker: Is there a second?

Doctor Powell: I request the privilege of the floor to discuss it.

The Speaker: The motion has not been seconded yet.

Doctor Maxon: I will second it.

The Speaker: It is now open for discussion. Doctor Powell.

The Speaker: I think that we should discuss this fully, and I don't think that anybody who wants to talk should be kept from talking.

Doctor Ingber: I move to recess for one hour.

The Speaker: Is there a second?

A Doctor: I second it.

The Speaker: All in favor of recessing for one hour say aye. Those opposed, no. The ayes have it.

(Whereupon a recess was taken for one hour.)

RECESS OF ONE HOUR

The House reconvened at 1:30 p. m.

The Speaker: I would like to announce at this time that we are still in executive session as passed by resolution yesterday, but if there is no objection the members of the State Dental Executive Board of the State Dental Society are meeting across the street, and I think if any of those men come over we will ask them to take seats in the back of the hall, if there is no objection. I would like to appoint a press release committee at this time, if there is no objection, consisting of Doctors J. B. Harris, Philip Gilman, William Molony, Harry Wilson, and George Kress, so that if any of the rest of you are approached by newspaper men, please refer them to the committee. Also the chairman of the Council, and the secretary, are appointed a committee to edit the minutes of this session and have them printed. Any inaccuracies will be corrected at the annual meeting at Yosemite.

Now, gentlemen, there are a number of our members from out of town who have to catch evening trains, and we do not want those men to have to go before these very important things are acted upon. Now, while there is no desire or inclination in the world to limit discussion, we will have to bear that in mind.

Doctor Wilson spoke.

Discussion was participated in by Doctors Powell, Shepherd, Ullmann, Lawson, Packard, Foster, Yoell, Wilson, Broadus, Anderson, Sciaroni.

\* \* \*

The Speaker: Those in favor of having the question without further debate, please say aye. Those opposed, no. Those in favor of limiting the debate on the question, say aye. Those opposed, no. Carried. It is moved and seconded that the recommendations of the committee upon this resolution be adopted.

Doctor Roblee: May we have a five-minute recess for district caucus?

The Speaker: I think we had better have the vote first.

Voices: Roll call.

The Speaker: What is the desire? Shall we have a five-minute recess for district caucus?

Voices: No.

A Voice: No, we haven't time. May the resolution be read again?

The Speaker: Do you want the resolution re-read?

Voices: No, no.

The Speaker: Those in favor will please rise. We are voting on the motion. You are voting on the adoption of the resolution and the recommendation of the committee. How many, Mr. Secretary?

The Secretary: Forty-eight.

The Speaker: Those opposed will please rise.

The Secretary: Sixty-three noes.

The Speaker: The vote is 48 for, 63 noes. The motion is lost. Doctor Gilman will read the next recommendation of the committee.

Doctor Gilman: Your committee recommends amending the above resolution as follows: Now, therefore, be it Resolved, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system which shall include the following principles:

(Reads principles.)

F. N. SCATENA  
P. K. GILMAN  
LOWELL S. GOIN

RESOLUTION NO. 2, INTRODUCED BY DR. IRVING S. INGBER

WHEREAS, The studies of the Committee of Five of the California Medical Association have shown the inability of a certain percentage of our population to adequately finance the cost entailed by illness; and

WHEREAS, Because of this economic situation proper medical care is beyond the reach of this population group; and

WHEREAS, It has been established that this problem can be alleviated by the utilization of the insurance principle; now therefore be it

*Resolved*, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital.

2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system.

3. There shall be no provision for cash benefits.

4. The patient shall receive adequate treatment and his physician shall receive adequate compensation.

5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended or approved by the profession; and be it further

*Resolved*, That the California Medical Association immediately offer its full aid and cooperation to the Interim Committee of the Senate of the State of California charged with the study of this problem, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

*Resolved*, That there be formed a special committee authorized and empowered to act herein, constituted as follows: The Legislative Committee of the Association and three members of the Association to be appointed by the Speaker of the House.

Doctor Gilman: That is the original resolution as submitted to your committee. Your committee modified the resolution as follows:

(Reads resolution as modified by the committee.)

Your committee, after correcting and changing the resolution, as I read it, recommends amending that changed resolution as follows: (Reading changes of bill.)

I move that it pass.

The Speaker: The adoption of this resolution has been moved. Is there a second?

Doctor Chandler: I second it.

The Speaker: The motion is now open to discussion.

Doctor Ingber: After staying in the Resolution Committee until midnight last night, we all agreed and accepted certain changes in the original resolution, which contained in the paragraph thereof the lines "that the House of Delegates of the California Medical Association discuss that legislation and the proposal seeking to establish a health insurance system mandatory as to certain population groups, and voluntary as to certain population groups, which shall include the

following principles," and I went home and went to bed and thought that was the end of it. This morning when I arrived here I was told that it had been changed again, although we had had no opportunity of conference, and the change then was the deletion of the mandatory and the voluntary lines. Now, I ask for consideration of the resolution on the original resolution as first amended, leaving in the mandatory and voluntary, and it is only fair that shall be done, otherwise it is no recommendation at all, and we are in a position where we sent our committee up to Sacramento after a year's work and the expenditure of \$84,000, and the unanimous opinion of the Advisory Committee and the Committee of Five that something definite shall be done, and the recommendation is compulsory and voluntary, and we get up there with nothing. You cannot do that, gentlemen, and I think it is fair that this original resolution as first amended shall be the resolution which should be presented to the House.

The Speaker: The only way that can be presented, Doctor Ingber, is for someone to move that the recommendation be amended.

Doctor Yoell: I move that the recommendation be so amended: That the first amendment be submitted and received in order.

A Doctor: I second it.

The Speaker: Will someone make a motion that the recommendations of the committee be amended, and then state what those amendments are? State definitely what amendments you want to make to the recommendation as read by Doctor Gilman.

Doctor Ingber: I wish to make the amendment that the lines "mandatory as to certain population groups," and "voluntary as to certain population groups," remain in the resolution.

Doctor Yoell: I second the motion.

The Speaker: Now, of course, in voting on this amendment you are not adopting the resolution. You are only amending it for consideration. Are there any remarks?

(Cries of "Question.")

The Speaker: Those in favor of the amendment as moved will say, aye. Opposed, no. The motion seems to be lost.

Voices: No, no.

The Speaker: Those in favor will please stand. Those opposed will stand. I think that is sufficient. The motion is carried, and the amendment is adopted.\*

\* \* \*

Doctor Ingber: May I present this resolution to the House?

The Speaker: Doctor Ingber has the floor.

Doctor Ingber: I wish to present the following resolution for the consideration of the House of Delegates. (Reading:)

"Whereas, the studies of the Committee of Five—  
(Reads resolution.)

Doctor Wilson: I would like to have the doctor determine first what group is going to determine what constitutes medical control, and if we accept compulsion and do recommend through the committee to the Interim Committee, and then do not get the things which we wish, are we going to withdraw and take our licking after we have committed ourselves?

(Cries of "Question.")

The Speaker: Doctor Burns.

A Voice: Is there a second?

The Speaker: Roy Brooks seconded it.

The following discussed the question: Doctors Burns, Dietrich, Harris, Molony, Moody.

The Speaker: It has been moved and seconded that the recommendation of the committee as amended be adopted.

The Speaker: It has been moved and seconded that the recommendation of the committee as amended be adopted. Those in favor say, aye.

\* Editor's Note.—The Revised Ingber Resolution No. 2, as adopted by the House of Delegates on March 3, 1935, is printed in this issue on page 187.

Doctor Brooks: I move that this resolution be adopted unanimously.

Doctor Green: I second it.

The Speaker: It has been moved and seconded that the vote on this question be made unanimous. Are there any remarks?

Doctor Schaupp: We asked for an expression of opinion. I think that we should not give out misinformation as to what action happened here. I think it should not be unanimous.

Doctor Crosby: Feeling that this is fraught with many questionable things in the minds of many of us, I think that the honesty of purpose, the honesty of vision of the people who have presented this can not be questioned, but I do not think, however, that it should not be made unanimous.

The Speaker: Any other remarks?

Doctor Brooks: My idea in making this motion was this, that we live in a republican form of government, and after a question has been fully discussed, both pro and con, and then voted upon, it is the custom in this country to follow the majority, and one other thing is the effect it would have at Sacramento if we went up there with the understanding that this resolution went through the House unanimously. I think it has a second to it. If it is the pleasure of the House of Delegates that I withdraw the motion, I will be glad to do it.

(Calls of question.)

The Speaker: I think inasmuch as it is obviously not unanimous it would be better to withdraw it.

Doctor Brooks: I so do.

The Speaker: Who seconded the motion?

Doctor Green: I did.

The Speaker: Doctor Green seconded it.

Doctor Green: I withdraw it.

The Speaker: Doctor Green seconded it, but he withdraws his second, and it is withdrawn.

#### THE MINORITY REPORT ON THE REPORT OF THE COMMITTEE OF FIVE

Doctor Gilman: (Reading) "The minority report of the Committee of Five."

Doctor Yoell: That is my report. If it is the pleasure of the House, I will withdraw it.

The Speaker: If there is no objection, Doctor Yoell will be permitted to withdraw his report from consideration.

Doctor Gilman:

#### COUNCIL RECOMMENDATIONS

The questions upon which the Council has requested your determination have (with the exception here and after noted) been presented to you in the various resolutions reported upon by this committee. The one exception is:

If the House of Delegates favors a compulsory plan of health insurance, shall it be provided by legislative enactment, initiative act or constitutional amendment?

Two points are involved in this question:

(1) Would a statute passed by the legislature providing for a compulsory system be constitutional?

(2) Assuming that such a law would be constitutional, does the Association as a matter of judgment favor entering upon such a plan in which the minimum fundamental principles are of such vital importance to the public and profession by means of a legislative enactment subject to possible destructive amendment at each succeeding session of the legislature?

The committee recommends that any compulsory health insurance system approved by the House of Delegates containing the fundamental principles which it is vitally necessary to maintain should be enacted by an initiative measure. Such a measure can be so drawn that any specified provisions thereof can thereafter be amended by another initiative measure.

The committee recommends the adoption of this principle by the House and that the whole determination of this vital question rests with the House.

F. N. SCATENA  
P. K. GILMAN  
LOWELL S. GOIN

The Speaker: Doctor Yoell.

Doctor Yoell: I move that the matters under consideration in that report be submitted to the committee that was created by the previous motion. That is properly and technically a legal matter, and the question would necessarily be passed on by them.

I hesitate to take the floor again, but there are two very interesting points brought up here that are questions of legal technique. It would be a tremendous advantage if the fundamental points of this bill, whatever the bill is that comes up, be carried and authenticated, so to speak, by an initiative or a constitutional amendment, but apparently on the opinion of briefs of excellent attorneys, the legislature can act and then have this question referred, if it wishes, to an initiative, and if the legislature acts and any one wishes to challenge the constitutionality of that, they can do so before that is submitted to the people. If we say to this committee that they shall only wait for the constitutional initiative, we still may lose out, so if we turn this matter over to the committee and abide by the decision we can also have the legislature pass it, and call for an initiative at the same time, and we can work for that initiative.

Doctor Brooks: I second that motion.

The Speaker: Are there any other remarks? It has been moved and seconded that this matter of legislation on initiative or referendum be not determined at this time, but that it be submitted to the committee consisting of the legislative committee and of the three which has been ordered by the previous action of the House.

Doctor Chandler: There is a resolution to be referred to Committee No. 2 in the House at a later time on this matter which covers the technical features that the Legislative Committee and its counsel will need to further the purposes expressed in the first resolution.

The Speaker: Any other remarks? Those in favor say, aye. Opposed, no. It is carried. The secretary reminds me, and he is correct, that there should be a motion that the report of the Reference Committee No. 1, as amended, be adopted as a whole.

Doctor Ullmann: I make that motion.

Doctor Kelly: I second it.

The Speaker: It is moved and seconded that the report as a whole be approved. Those in favor say aye. Opposed, no. Carried.

#### REPORTS OF REFERENCE COMMITTEE No. 2

The Speaker: Now, Doctor Howson, chairman of Committee No. 2.

Doctor Howson: (Reading) "Report of Reference Committee No. 2." (Reads.)

There is also the further resolution that was submitted this morning by Doctor Scatena. This resolution has been amended to read as follows:

#### RESOLUTION PRESENTED BY DOCTOR SCATENA AS AMENDED BY REFERENCE COMMITTEE NO. 2

WHEREAS, The House of Delegates of the California Medical Association have indicated their desire to support a form of sickness insurance; now, therefore, be it

*Resolved*, That the Council and the Legislative Committee of the Association are hereby authorized and empowered to meet any contingencies arising in the legislature or elsewhere by supporting or opposing any measures relating to medical or hospital service or sickness insurance, taking such action as will in the opinion of the Council best subserve and

fulfill the principles and the plans laid down by the House of Delegates.

Recommended do pass.

REFERENCE COMMITTEE NO. 2,  
L. R. CHANDLER  
GEORGE H. KRESS  
CARL R. HOWSON

Your committee recommends the passage of this resolution.

Doctor Bolin: I second the motion.

The Speaker: It has been moved and seconded that this resolution be adopted. Are there any remarks?

(Cries of, "Question.")

The Speaker: Those in favor say aye. Opposed no. Carried.

Doctor Howson:

COUNCIL RESOLUTION A AS AMENDED BY REFERENCE  
COMMITTEE NO. 2

WHEREAS, It appears that efforts may be made at the present session of the legislature to legalize the practice of medicine for profit by corporations, as insurance or otherwise; be it

*Resolved*, That the California Medical Association condemns and is opposed to all legislation which would be inimical to public health and/or destructive to proper standards of medical service.

Recommend do pass.

REFERENCE COMMITTEE NO. 2,  
L. R. CHANDLER  
GEORGE H. KRESS  
CARL R. HOWSON

Your committee recommends that this resolution do pass.

Doctor Madsen: I second the motion.

The Speaker: Are there any remarks? Those in favor say, aye. Opposed, no. Carried.

Doctor Howson: (Reading) As amended.  
(Resolution read.)

COUNCIL RESOLUTION B AS AMENDED BY REFERENCE  
COMMITTEE NO. 2

WHEREAS, Bills have been introduced in the legislature opening county hospitals to all who apply for admittance, even though the applicants possess the means to pay for private hospital and medical service; and

WHEREAS, The enactment of any such legislation would throw an unnecessary and unjust burden upon the taxpayers of the county, and would tend to destroy large investments in existing private hospitals; now, therefore, be it

*Resolved*, That the California Medical Association is strongly opposed to such legislation.

Recommend do pass.

REFERENCE COMMITTEE NO. 2,  
L. R. CHANDLER  
GEORGE H. KRESS  
CARL R. HOWSON

Your committee recommends that this resolution do pass.

Doctor Ullmann: I second it.

(Cries of, "Question.")

The Speaker: Those in favor say aye. Opposed no. Carried.

Doctor Howson: Council Resolution C, as amended.  
(Reads.)

COUNCIL RESOLUTION C AS AMENDED BY REFERENCE  
COMMITTEE NO. 2

WHEREAS, There has been no coordinated statewide plan for the care of the sick on unemployment relief in California; and

WHEREAS, The Federal Administration has recognized the fundamental character of medical care by grouping it with food, shelter and clothing in its relief plans; and

WHEREAS, The physicians of California who have been giving of their time and skill in the care of the sick on unemployment relief should not be expected to bear this burden any more than those citizens providing the other necessities of life; and

WHEREAS, The California Medical Association and various county medical associations in California have repeatedly offered and made available their services for furnishing such care, but without avail; now, therefore, be it

*Resolved*, That the House of Delegates of the California Medical Association deprecates the delay of the Federal and State Emergency Relief Administration in establishing a proper plan in conjunction with organized medicine and its allied professional groups, and urges that all interfering matters be subordinated to the early establishment of proper medical care for the sick upon unemployment relief in California.

Recommend do pass.

REFERENCE COMMITTEE NO. 2,  
L. R. CHANDLER  
GEORGE H. KRESS  
CARL R. HOWSON

Your committee moves the adoption of that resolution.

Doctor Green: I second it.

The Speaker: Any discussion?

(Cries of, "Question.")

The Speaker: Those in favor say aye. Opposed no. Carried.

Doctor Howson: This is the first of the two resolutions into which the committee split the resolution presented by Dr. C. Max Anderson, as amended.

RESOLUTION PRESENTED BY DR. C. MAX ANDERSON, AS AMENDED  
BY REFERENCE COMMITTEE NO. 2

WHEREAS, It appears that the cost of medical care is at times a serious burden to the average family, and that the economic spread of its cost is not only desirable but essential to the welfare of society; and

WHEREAS, The medical profession is being pauperized, and a pauperized medical profession cannot give to the people of this country the class of medical service which they expect and demand; and

WHEREAS, The plans of medical service in Europe are unsatisfactory for this country; and

WHEREAS, Most of the plans being advanced in this country are the entering wedge for socialized medicine, which we oppose as inimical to the best interests of society and the profession; and

WHEREAS, We believe that the free choice of physician is essential to the proper physician-patient relationship; and

WHEREAS, We believe there should be no intervention of laymen between doctor and patient; and

WHEREAS, There should be no regimentation and subjugation of the medical profession by lay authority; and

WHEREAS, Commercialization of medicine is to be avoided; and

WHEREAS, Political abuses are inherent in most schemes of health insurance; and

WHEREAS, We are opposed to the medical profession entering the insurance field itself; and

WHEREAS, We believe a limited insurance association subsidized and controlled by the State is the best and most satisfactory solution of the problem; now, therefore, be it

*Resolved*, By this House of Delegates that a bill for a plan of mutual cash benefits for sickness on a true insurance basis, payment being made to the insured in cash and not in service, be prepared by the proper

committee and presented to the State legislature, this payment to be in such form that the insured could apply it only to payment for medical care.

Submitted without recommendation.

REFERENCE COMMITTEE, No. 2,  
L. R. CHANDLER  
GEORGE H. KRESS  
CARL R. HOWSON

This resolution is submitted without recommendation.

Doctor Moody: I move its passage.

Doctor Ingber: I second it.

The Speaker: Any discussion?

(Cries of question.)

The Speaker: Those in favor say aye. Opposed no. I believe I will ask Doctor Howson to read that again. There seems to be a little bit of doubt about what it is. (Resolution again read.)

The Speaker: We will take the vote again. Are there any remarks?

Doctor Shephard: There is just one thing that comes to my mind in reference to that resolution. It can be very easily interpreted from the standpoint of the socially-minded individual that they will leave it up to that Board on furthering their ideas of opening the county hospitals and having the indigent taken care of by a full paid staff, such as they are trying to do over in Kern County. While I think we are all in sympathy with the amending of the resolution and what the Doctor has in mind, but as a matter of political expediency it might be well to keep quiet on it at this time.

The Speaker: Any further remarks? Those in favor will say, aye. Opposed, no. The motion seems to be lost. The motion is lost.

Doctor Howson: The second resolution by Doctor Anderson.

RESOLUTION PRESENTED BY DR. C. MAX ANDERSON, AS AMENDED BY REFERENCE COMMITTEE NO. 2

WHEREAS, The medical profession have too long carried the load of the cost of sickness of the indigent patient; and

WHEREAS, The large class of people unable to pay for medical care is the responsibility of the public; now, therefore, be it

Resolved, By this House of Delegates in special session assembled, that it is the sense of these delegates that the financial burden of medical care for the indigent should be lifted from the backs of the members of the medical profession and placed where it belongs as a financial responsibility of the public.

Submitted without recommendation.

REFERENCE COMMITTEE No. 2,  
L. R. CHANDLER  
GEORGE H. KRESS  
CARL R. HOWSON

This resolution is submitted by your committee without recommendation.

The Speaker: A motion is now in order.

Doctor Porter: I move it do not pass.

Doctor Crosby: I second the motion.

The Speaker: Doctor Porter moves it do not pass, and that is seconded by Doctor Crosby. Those in favor say, aye. Those opposed, no. Carried.

Doctor Howson: I move the report of the committee as a whole be adopted.

Doctor Reiss: I second it.

The Speaker: It is moved and seconded that the report of Reference Committee No. 2 be adopted as a whole. Any remarks? Those in favor say, aye. Opposed, no. Carried. We are almost through, gentlemen.

RESOLUTION OF THANKS TO THE LOS ANGELES COUNTY MEDICAL ASSOCIATION

Doctor Ingber: I wish to present this resolution: Resolved, That it is the sense of this House of Delegates that we thank the Los Angeles County Medical

Association for the very unusual courtesies they have extended us; for the very gracious reception they have given us in this beautiful and most convenient place of assembly; for the splendid spreading of the fat of the land on their tables so that we might be fortified to proceed with our deliberations; and lastly, because the spirit of good fellowship which they did so much to create has made it possible that we carry home to our confrères the message that at Los Angeles in March, 1935, California medicine met its responsibilities.

Doctor Powell: I second it.

The Speaker: You have heard the motion. Are there any remarks?

Doctor Kelly: I would like to amend it to read that in addition to all of those things, which we thank them for in the first paragraph, that we thank them for the thunder storm yesterday afternoon.

The Speaker: That will go to the weather man. (Laughter.) Those in favor say aye. Opposed, no. Carried. The ayes seem to have it. The motion is carried.

RESOLUTION ON COÖPERATION WITH SENATE INTERIM COMMITTEE

Doctor Molony: Mr. Speaker: I wish to present the following resolution:

Resolved, That the House of Delegates of the California Medical Association, in special session assembled at Los Angeles, California, this third day of March, 1935, hereby expresses its thanks and appreciation to the Interim Committee of the Senate of the State of California, consisting of Honorable Dan E. Williams (chairman), Honorable Edward H. Tickle, and the Honorable Leonard Difani, and Celestine Sullivan, for its coöperation with the Committee of Five and the Council of this Association in the study of problems of sickness costs and sickness insurance.

Doctor Molony: I move its adoption.

Doctor Ingber: I second the motion.

Doctor Yoell: I would like to amend that motion to include the secretary of that coördination committee, who has a definite function.

Doctor Kelly: I second it.

The Speaker: It is moved and seconded that the resolution be amended to include the coördinating secretary. Are there any remarks? Those in favor say aye. Opposed, no. The vote is now upon the original motion, as amended. Any remarks? Those in favor say, aye. Opposed, no. It is carried. I would like at this time to reannounce this Press Committee. Many of you who were not here did not hear that: Doctors J. B. Harris, Philip Gilman, William Molony, Harry Wilson, and George H. Kress. Please refer all newspapermen to this committee. Now, there will be a Council meeting immediately following our adjournment. Now, gentlemen, we have lots of time. We have heard a lot of good oratory, but we have time for a little more, and I am going to, without any warning to him, call on the president of the California Medical Association to address you. (Applause.)

REMARKS BY PRESIDENT TOLAND

Doctor Toland: Mr. Speaker and members of the House of Delegates: You know the Los Angeles County Medical Association—of course I can't help speak for it because I live here—certainly feels grateful to you and highly complimented by your presence during these deliberations. I want to say to you that I think I have heard some of the best arguments, both pro and con, during this meeting of any meeting of any other House of Delegates I ever attended. Some very consistent things were said, and some very good things were done, and you men have voted to do certain things. If we will carry on and stick together, we can do it. Let's work it out to a real great end.

I wish to say that the California Medical Association should compliment its Committee of Five for the enormous amount of work it has done. I have had the privilege to be present at several meetings, and it was an all-day meeting every time. The work was thoroughly done, and without any particular thought of trying to disturb any one group of men in this profession, be-

cause they were trying to come to some conclusion that would help you and help the people of the State of California. I wish to say they are great men, all of whom would be a credit to the profession of any state. I have had an opportunity to visit many of the county medical societies of the State where I have met many brilliant doctors all endeavoring to do something worth while for their fellow man and their colleagues.

Dr. Dodd, who is the director of the survey, has worked all the time. He has traveled up and down the coast not only in this state but other states and even in the east to obtain data that might have some bearing on our survey.

I wish you all to remember that the Interim Committee, when they have met with the members of the Council, have laid their cards on the table showing they are anxious to cooperate with us. Our Council and our Legislative Committee have shown the same spirit toward the Interim Committee.

I want to thank you very much and assure you that we of the Los Angeles County Medical Association appreciate the opportunity to entertain you during your stay in Los Angeles. Thank you.

#### RESOLUTION OF THANKS TO THE COMMITTEE OF FIVE, THE DIRECTORS OF THE SURVEY, AND THE ADVISORY COMMITTEE

Doctor Ingber: Mr. Chairman, if a resolution is in order, I would like to have a resolution passed thanking Doctor Dodd and the Advisory Committee, the Committee of Five, for their painstaking efforts in giving us one of the finest surveys ever made in the United States.

The Speaker: Doctor Dodd and staff.

Doctor Ingber: Yes, sir, and the advisory staff.

Doctor Landrock: I second it.

The Speaker: It is seconded by Doctor Landrock of Marin County. Any remarks? Those in favor say, aye. Opposed, no. Carried.

#### REMARKS BY PRESIDENT-ELECT PEERS

Now, gentlemen, I am sure you have enjoyed the address of the president, and I am sure you will enjoy the address of the president-elect just as well. (Applause.)

Doctor Peers: Mr. Speaker, and members of the House of Delegates: I thank you very much for that reception, as I also thank you for the great honor that you have given me last year. I want to say that I agree with the remarks of our president, except perhaps as they referred to the Committee of Five. I think that we should all work together. I want to assure that, as an elected officer of this Association, elected by this House of Delegates, I will do everything in my power to carry out the wishes of the House of Delegates. (Applause.)

#### REMARKS BY VICE-SPEAKER GRAVES

The Speaker: Now, gentlemen, we have with us one of our officers who has not had a great deal to do because of my own selfishness, and that is the vice-speaker, Dr. John Graves.

Doctor Graves: Gentlemen: I would like to have you just understand that I not only agree, but like to repeat over and over again all the fine things that have been said of these committees, the Los Angeles County Medical Society, and all of the lovely things that you are entitled to.

A few years ago, three or four years ago, Ray Lyman Wilbur said—and as usual it has worked out that way—that the college professor is wrong, that the only way that the medical profession would ever go into any kind of a health insurance plan would be by the same method that a cat went across the carpet when you grabbed him by the tail and pulled him backward. (Laughter.) Now, we have proven that our good friend Doctor Wilbur was wrong, because you are not going across the carpet backward with a legislative committee on the part of the State of California pulling your tail. On the other hand, you are going like Colonel Roosevelt did at San Juan. When somebody complimented him upon his bravery in lead-

ing that charge, he said, "I didn't lead it, I had to go like hell to keep the boys from running over me." (Laughter.)

And so in that spirit, going ahead, shoulder to shoulder, and with a sure foot, I am sure that we will do a great deal for the people of California, and we are also going to protect all of our own legitimate interests, and even make things better. Thank you. (Applause.)

#### REMARKS BY COUNCIL CHAIRMAN KELLY

The Speaker: Now, gentlemen, there is one part of this Association which sometimes I think has not been fully appreciated, and that is the Council. I know after the adjournment of the Riverside meeting, which meeting lasted until 2 o'clock in the morning, I never was at any other time in my life so fatigued, and it was not because of the House of Delegates' meeting either. It was because of those Council meetings that drag on and drag on. We cannot help it. There was so much work to do. We met all day Friday, and all forenoon Saturday, and we had an adjourned meeting last night, and now we have another meeting tonight after we get through, and I am going to call on Tom Kelly, the chairman of the Council.

Doctor Kelly: Because the Council has to have an adjourned meeting after this House adjourns, I am going to make this short. I only want to express my appreciation at the way the Council has worked this year, and there has been plenty of work for the Council to do this year. The other thing that I want to say to the House of Delegates is that we sat here today and we voted a new departure in the medical practice in the United States. It was not an unanimous vote, and you could put me down in the book that I didn't vote to make it unanimous because I think that in this departure the men who didn't agree with it should still be on record as not having agreed with it, but that is the action of the House of Delegates and I want to urge all the delegates, no matter how they voted, now to go back home and to carry out what the House did, not try to put any sand in the gear boxes, because we are going to have a fine job at Sacramento, no matter how cooperative the Interim Committee itself is, in keeping the principles that we want to see in any bill that may be presented to the legislature, and the work of the Special Committee that was appointed today in the resolution to see that the bill was made up in the best form, and the work of the Council which we will have to do, and all of the work mentioned, will be materially aided by the solid front that Doctor Graves talked about. We have a job to do now. I don't think, unless some of you have had more or less contact with that legislature, that you realize what the committee has got to do in the next three or four months, and the only thing that will ease its work at all is a message from each one of you men back to his own county society to forget now that there are three kinds of medical practice, there is just one that we are going after at the present time to have it the way we want it. Thank you. (Applause.)

#### REMARKS BY SECRETARY WARNSHUIS

The Speaker: I have been trying to persuade our secretary to speak, but he says no, and I am going to call on him anyway. Dr. Fred Warnshuis.

Doctor Warnshuis: Mr. Speaker, President Toland, and President-Elect Doctor Peers, and members of the House of Delegates: I desire to express to you my sincere appreciation of the kind and cordial reception that you have given to me, and I want to embrace this opportunity of stating to you that as secretary of your Association I have no other object than to serve you and to carry out your wishes, and that whenever this office can be of service to you it is yours to command, and we shall respond. I thank you. (Applause.)

#### REMARKS BY CHAIRMAN HARRIS OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

The Speaker: Now, there is just one other man that I want to call on, and then a motion to adjourn will be in order. Since the Riverside meeting the body that

has been holding big in the California Medical Association has been the Committee of Five, but their work is about finished. The House of Delegates, which is the supreme body in the California Medical Association, has met here and they have accepted with approval the work of that committee. Now, the thing that is going to loom big in the next three months is this newly-created Legislative Committee, the three members of the Legislative Committee, as that committee already exists, and the three yet to be appointed. I am going to call on the chairman of the present Legislative Committee, Dr. J. B. Harris.

Doctor Harris: Mr. Speaker and members of the House of Delegates: I know that we have a big job before us, not only going through and watching for these Nubians in the woodpile, but of doing the work of putting forward this wonderful constructive business of legislation that you have handed us today. Luckily, I am physically now in good shape to carry on this work. (Applause.) I am like the Dutchman who was bet that he could not drink a bucket of beer without taking a breath, and he went out and returned in a few minutes and wiped off his mouth, and he says, "I can do it, I will bet you." (Laughter.)

I have been down for an extended vacation to Palm Springs. I have called on every member, I think, of the profession that does eye, nose and throat work and asked his advice, and they all told me to go to Palm Springs and get out of the fogs that exist in Sacramento—and it is pretty foggy there at times—and to get in the sunshine, and so I went out to Palm Springs. We saw cloudbursts and floods, thunder and lightning, snow-storms and sand-storms, and we went through rigors that would bring tears to the eyes of Admiral Byrd when I go to him and tell him about it.

A Voice: Did you get well?

Doctor Harris: Yes. I had to get well. I will fight to the finish. That is why I am so confident I will be able to carry on with this work. (Applause.)

The Speaker: Knowing June so well, I can't leave this hall without asking you to remember that I call upon all of you fellows here for a rising vote for June's past record in our behalf.

(A rising vote.)

#### ADJOURNMENT

Doctor Kelly: I move we adjourn, Mr. Speaker.

Doctor Ingber: I second the motion.

The Speaker: Those in favor will say, aye. Opposed, no. It seems to have carried.

Attest: F. C. WARSNUIS, Secretary.

#### DELEGATES ATTENDING SPECIAL SESSION AT LOS ANGELES ON MARCH 2-3, 1935

(Note: Figures following names indicate dates of attendance)

(EX OFFICIO)	March		March
Toland, Clarence G.....	2-3	CONTRA COSTA COUNTY	
Peers, Robert A.....	2-3	Abbott, U. S.....	2-3
Pallette, Edw. M.....	2-3	FRESNO COUNTY	
Graves, John H.....	2-3	Sciaroni, George H.....	2-3
Kelly, T. Henshaw.....	2-3	Madden, Thomas.....	2-3
Gibbons, M. R.....	2-3	Walker, George W.....	2-3
Schaupp, Karl L.....	2-3	HUMBOLDT COUNTY	
Dukes, Charles A.....	2-3	No delegate present	
Kress, George H.....	2-3	IMPERIAL COUNTY	
Roble, W. W.....	2-3	Holleran, G. C.....	2-3
Howson, Carl R.....	2-3	KERN COUNTY	
Ullmann, Henry J.....	2-3	Packard, L. A.....	2-3
DeLappe, Fred R.....	2-3	KINGS COUNTY	
Phillips, Alfred L.....	2-3	Pratt, B. H.....	2-3
Hamlin, C. D.....	2-3	LASSEN-PLUMAS COUNTIES	
Schoff, C. E.....	2-3	Martin, G. S.....	2-3
Rogers, Henry S.....	2-3	MARIN COUNTY	
Wilson, Harry H.....	2-3	Landrock, George M. 2-3	
Tanner, C. O.....	2-3	MENDOCINO COUNTY	
Kiger, W. H.....	2-3	Cushman, Ruggles A. 2-3	
Harris, J. B.....	2-3	MERCED COUNTY	
		Parker, A. S.....	2-3
ALAMEDA COUNTY		MONTEREY COUNTY	
Adams, L. P.....	2-3	Wolfsohn, Mast.....	2-3
Crosby, Daniel.....	2-3		
Dukes, C. A.....	2-3		
Moore, Gertrude.....	2-3		
Glenn, R. A.....	2-3		
Lawson, T. C.....	2-3		
Makinson, F. R.....	2-3		
Meads, A. M.....	2-3		
Sargent, W. H.....	2-3		
BUTTE COUNTY			
Enloe, N. T.....	2-3		

#### NAPA COUNTY March

Dawson, George L..... 2-3

#### ORANGE COUNTY

Ball, D. R..... 2-3

Huffman, H. G..... 2-3

Maroon, S. J. L..... 2-3

#### PLACER COUNTY

No delegate present

#### LOS ANGELES COUNTY

Anderson, C. Max..... 2-3

Axline, Joseph T..... 2-3

Blong, Peter H..... 2-3

\*Breyer, J. H..... 2-3

Briggs, Wilford..... 2-3

\*Brown, Harry W..... 2-3

Burns, E. M..... 2-3

Clarke, Fred B..... 2-3

Crossan, John W..... 2-3

Crane, Jay J..... 2-3

Daniel, Wm. H..... 2-3

Dietrich, Henry..... 2-3

Dock, George..... 2

\*Dunlop, John..... 2-3

Ghrist, Orrie E..... 2-3

Gleeten, Scott D..... 2-3

Godwin, Deon E..... 2-3

Goin, Lowell S..... 2-3

\*Klein, J. M..... 2-3

Madsen, Leo J..... 2-3

Maner, George D..... 2-3

McKee, W. C..... 2-3

Molony, Wm. R., Sr..... 2-3

Moody, E. Earl..... 2-3

Nuttall, John P..... 2-3

Ramsay, Robert E..... 2-3

Reiss, Oscar..... 2-3

Ruddock, John C..... 2-3

Scott, A. J..... 2-3

Wessels, Walter..... 2-3

Snure, Henry..... 2-3

Stephens, Philip..... 2-3

Sturgeon, Charles T..... 2-3

\*Swindt, Joseph H..... 2-3

Webber, W. T..... 3

Wilcox, Robert W..... 2-3

#### ALTERNATES

Pottenger, F. M..... 2

Shuman, John..... 2-3

Larsen, Eric..... 2-3

#### RIVERSIDE COUNTY

Carl, Thomas A..... 2-3

Coon, G. Wayland..... 2-3

#### SACRAMENTO COUNTY

Hale, Nathan..... 3

Briggs, G. A..... 2-3

Scatena, Frederick..... 2-3

#### SAN BENITO COUNTY

No delegate present

#### SAN BERNARDINO COUNTY

Gage, A. T..... 2

Hull, E. H..... 2-3

Whitmer, C. F..... 2

Gentry, H. G..... 3

#### SAN DIEGO COUNTY March

Garth, W. L..... 2-3

Holder, Hall G..... 2-3

Huff, George D..... 2-3

\*Ledford, R. M..... 2-3

McClendon, S. J..... 2-3

Kinney, Lyell C..... 3

#### SAN FRANCISCO COUNTY

Bolin, Zera..... 2-3

Brooks, LeRoy..... 2-3

Bruck, Edwin L..... 2-3

Chandler, L. R..... 2-3

Garland, L. H..... 2-3

Gilman, Philip..... 2-3

Hosford, George N..... 2-3

Ingber, Irving..... 2-3

Kerr, Wm. J..... 2-3

Kilgore, Alson..... 2-3

Pierce, George W..... 2-3

Porter, Langley..... 2-3

Swett, Wilber F..... 2-3

Rhodes, George K..... 2-3

Thorne, I. W..... 2-3

Yoell, Rodney A..... 2-3

#### SAN JOAQUIN COUNTY

Powell, Dewey..... 2-3

Broadus, C. A..... 2-3

#### SAN LUIS OBISPO COUNTY

Sobey, G. L..... 2-3

#### SAN MATEO COUNTY

Ray Hartzell H..... 2-3

#### SANTA BARBARA COUNTY

Evans, Richard..... 2-3

Freidell, Hugh..... 2-3

#### SANTA CLARA COUNTY

Canelo, C. Kelly..... 2-3

Kneeshaw, R. Stanley 2-3

Van Dalsem, S. B..... 2-3

Shepherd, J. H..... 2-3

#### SANTA CRUZ COUNTY

No delegate present

#### SHASTA COUNTY

No delegate present

#### SISKIYOU COUNTY

Hart, V. W..... 2-3

#### SOLANO COUNTY

Green, John W..... 2-3

#### SONOMA COUNTY

Butler, F. O..... 2-3

#### STANISLAUS COUNTY

Hartman, Hans..... 2-3

#### TEHAMA COUNTY

Frey, R. G..... 2-3

#### TULARE COUNTY

Kohn, Frank..... 2-3

#### VENTURA COUNTY

Morrison, A. R..... 2-3

#### YOLO-COLUSA-GLENN COUNTIES

Poage, C. A..... 2-3

#### YUBA-SUTTER COUNTIES

Hamilton, R. L..... 2

\* Did not attend.

#### ADDENDA

#### MISCELLANEOUS RESOLUTIONS AND REFERENCES ON THE SUBJECT OF SICKNESS INSURANCE

**Report of Reference Committee—Special Session, House of Delegates of the American Medical Association, February 15 and 16, 1935.**—Your Reference Committee, believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of medical service now available to the American people, condemns unreservedly all propaganda, legislation or political manipulation leading to these ends.

Your Reference Committee has given careful consideration to the record by the Board of Trustees of the previous actions of this House of Delegates concerning sickness insurance and organized medical care and to the account of the measures taken by the Board of Trustees and the officials of the Association to present this point of view to the Government and to the people.

The American Medical Association, embracing in its membership some one hundred thousand of the physicians of the United States, is by far the largest medical organization in this country. The House of

Delegates would point out that the *American Medical Association is the only medical organization open to all reputable physicians and established on truly democratic principles, and that this House of Delegates, as constituted, is the only body truly representative of the medical profession.*

The House of Delegates commends the Board of Trustees and the officers of the Association for their efforts in presenting correctly, maintaining and promoting the policies and principles heretofore established by this body.

The primary considerations of the physicians constituting the American Medical Association are the welfare of the people, the preservation of their health and their care in sickness, the advancement of medical science, the improvement of medical care, and the provision of adequate medical service to all the people. These physicians are the only body in the United States qualified by experience and training to guide and suitably control plans for the provision of medical care. The fact that the quality of medical service to the people of the United States today is better than that of any other country in the world is evidence of the extent to which the American medical profession has fulfilled its obligations.

The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal Government, the governments of the individual states, or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

The medical profession has given of its utmost to the American people, not only in this but in every previous emergency. It has never required compulsion, but has always volunteered its services in anticipation of their need.

The Committee on Economic Security, appointed by the President of the United States, presented in a preliminary report to Congress on January 17 eleven principles which that committee considered fundamental to a proposed plan of compulsory health insurance. The House of Delegates is glad to recognize that some of the fundamental considerations for an adequate, reliable and safe medical service established by the medical profession through years of experience in medical practice are found by the committee to be essential to its own plans.

However, so many inconsistencies and incompatibilities are apparent in the report of the President's Committee on Economic Security thus far presented that many more facts and details are necessary for a proper consideration.

The House of Delegates recognizes the necessity under conditions of emergency for federal aid in meeting basic needs of the indigent; it deprecates, however, any provision whereby federal subsidies for medical services are administered and controlled by a lay bureau. While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplores and protests those sections of the Wagner Bill which place in the Children's Bureau of the Department of Labor the responsibility for the administration of funds for these purposes.

The House of Delegates condemns as pernicious that section of the Wagner Bill which creates a social insurance board without specification of the character

of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training.

The so-called Epstein Bill, proposed by the American Association for Social Security now being promoted with propaganda in the individual states, is a vicious, deceptive, dangerous and demoralizing measure. An analysis of this proposed law has been published by the American Medical Association. It introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration, and an inevitable trend toward social and financial bankruptcy.

The committee has studied this whole matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolutions from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and with curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June, 1934.\* The House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, installment purchase, or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physicians on the other.

Your Reference Committee suggests that the Board of Trustees request the Bureau of Medical Economics to study further the plans now existing and such as may develop, with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, the effects of such service on the medical profession, the applicability to rural, village, urban and industrial population, and to develop for presentation at the meeting of the American Medical Association in June model skeleton plans adapted to the needs of populations of various types.

(Signed) Dr. Harry H. Wilson, Chairman,  
California  
Dr. Warren F. Draper, Virginia  
Dr. E. F. Cody, Massachusetts  
Dr. E. H. Carey, Texas  
Dr. N. B. Van Etten, New York  
Dr. F. S. Crockett, Indiana  
Dr. W. F. Braasch, Minnesota

\*EDITOR'S NOTE: See page 52 of the July, 1934, issue of CALIFORNIA AND WESTERN MEDICINE for a summary of the fundamental principles adopted at the Cleveland session of the American Medical Association.

### State Dental Society of California Pass Resolutions on Health Insurance\*

#### RESOLUTION ON HEALTH INSURANCE ADOPTED BY THE COUNCILS OF THE CALIFORNIA AND SOUTHERN CALIFORNIA STATE DENTAL ASSOCIATIONS

WHEREAS, The studies of the California Medical Economic Survey have shown the inability of a certain percentage of our population to adequately finance the cost entailed by dental services; and

WHEREAS, Because of this economic situation it appears that proper dental care is beyond the reach of this population group; and

WHEREAS, It has been established that this problem can be alleviated by the utilization of the insurance principle; and

WHEREAS, A resolution of parallel intention has been adopted by the California Medical Association covering medical and hospital attention; now therefore be it

**Resolved**, That the Councils of the California and Southern California State Dental Associations recommend that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of dentist and hospital.
2. The dental professions shall through their representative organization determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, dental, and dental auxiliary services rendered under the system.
3. There shall be no provision for cash benefits.
4. The patient shall receive adequate treatment and his dentist shall receive adequate compensation.
5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended, or approved by the profession. and be it further

**Resolved**, That the California and Southern California State Dental Associations immediately offer their full aid and cooperation to the Interim Committee of the Senate of the State of California, charged with the study of this problem, and the California Medical Association, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

**Resolved**, That there be formed a special committee authorized and empowered to act herein, constituted as follows: The presidents of the California and Southern California State Dental Associations, the chairmen of the Legislative Committees of the California and Southern California State Dental Associations, J. Franklyn Cook, and Ernest G. Sloman.

#### Association of California Hospitals: Its Viewpoint of Sickness Insurance.—The following letter of date of March 14, has been received by the editor:

"At the San Francisco Convention of the Western Hospital Association a California state association was set up known as the Association of California Hospitals. This Association took over all activities from the Western Hospital Association which concerned California hospitals.

"As President of this Association I wish to definitely offer our cooperation with the officers of the California Medical Association in working out our many complex, mutual problems. The hospital executives of California have only one objective in mind and that is to keep the California hospitals outstanding institutions rendering a truly public service and cooperating with the doctors of medicine in keeping the hospitals on an ethical basis.

\*To the Editor.—Enclosed please find a copy of the resolution adopted at a Joint Meeting of the Councils of the California and Southern California State Dental Associations in San Francisco on March 10, 1935. As you will recognize—it is nearly identical with the resolution adopted by the House of Delegates of the California State Medical Association at its meeting on Sunday, March 3, 1935, in Los Angeles.—Ernest G. Sloman, D. D.

"One of the big problems facing us at the present time is compulsory health insurance. The hospitals have been studying this proposition for some time and feel that there may be some solution of the acute hospitalization problem through compulsory health insurance by holding back the inroad of government institutions, which in reality works the same handicap for the medical profession. We, however, see many pitfalls with compulsory health insurance. We are practically of one mind that compulsory health insurance must be constructed and administered by medical men. I wish to also make it very emphatic that the hospitals of this Association as a group have formulated no set program and have never proposed any plan of compulsory health insurance.

"We have a Special Committee, namely, Ellard L. Slack, G. Waite Curtis, and R. E. Heerman, who have been delegated to work with your Association and other interested groups in proposing legislation that will be of the utmost service to the public. We believe this can be accomplished and still adhere to the following basic principles:

"First: That it must give free choice of physician and hospital.

"Second: That it must insure the patient securing practically the same high quality service as he is now receiving and eliminate some of the hazards that have grown up under socialized medicine and industrial medicine.

"Third: That hospitals should be paid adequate compensation to render high class hospital service and not be subject to cut-throat competition.

"I am writing you this letter so that you might know the principles and ideals back of this Association, and our willingness to cooperate in working out a solution of the problem so that this vital service to the public may be constructed in line with the interests of the ethical doctor of medicine."

Signed

R. E. Heerman, President.

1414 South Hope Street, Los Angeles.

**The Next Steps.\***—In all the addresses in this series certain facts have been emphasized again and again. By common consent the maintenance and improvement of health is a primary concern of every individual and therefore of organized society. It is well known that illness is no respecter of persons and constitutes the leading hazard in the life of the individual and of the family. The brilliant advances in medical knowledge of the last fifty years have greatly improved the weapons at our disposal both for the prevention and the treatment of disease, but unfortunately they remain largely unapplied. We have then two main problems confronting us as a people, first the more effective prevention of preventable disease, and second the wider availability of expert medical care. . . .

When we come to the problem of adequate medical care for the American people the steps to take are by no means so evident. There has long been a common impression that a large proportion of the public receives inadequate medical attention, but the facts brought out by the Committee on the Costs of Medical Care have shown a situation that cannot be disregarded and the condition is growing worse. . . .

Nothing could be more unjust than to charge the medical profession with responsibility. Not only the ideals but the practice of that profession entail an enormous amount of unremunerative work. In every community of the country the doctor has carried his load of unpaid service and too often without recognition of any sort. And as the years have passed the doctor's economic lot has reached a crisis. In 1929 one-third of all American physicians had net incomes of less than \$2500 a year and one-half of them less than \$3800. The Committee on the Costs of Medical Care found that if the incomes of private general physicians were graded

\*Excerpts from an address by Livingston Farrand, in the Public Health Series (Lecture 19). Sponsored by the National Advisory Council on Radio in Education

in income groups of \$1000, more would be found in the \$1000-\$2000 class than in any other.

Our problem of course is not of the well-to-do or wealthy patient or of the medical specialist or general practitioner of large practice in our cities. The problem to be solved is that of the poor and middle class patient and of the average doctor, dentist and nurse.

The studies referred to have also shown that on a reasonable distribution there are nearly enough qualified physicians in the United States adequately to care for the people were it not for the unfortunate concentration of the profession in our cities. The inevitable consequence is that great rural areas are left with insufficient medical care or even totally without it.

The natural question at once arises whether, under the circumstances, the American people could afford to pay for the kind of medical service which modern knowledge indicates as desirable. The immediate answer is that the people already pay nearly enough in any normal year to buy medical service for everyone. The best estimates have shown that an expenditure of \$36 per capita a year would meet the demands of reasonable standards, and conservative estimates also show that today we spend in the United States about \$30 per capita a year but with the totally unsatisfactory results just described. What then is the answer?

Numerous attempts have been made and are being made by the medical profession to solve the difficulty. Group practice in various forms, local cooperative plans and devices aimed at the problem of small groups have helped the situation locally but have not significantly affected the national picture.

The only promising solution to our difficulty would seem to be some plan whereby the costs of medical care can be distributed over large groups through the application of some insurance principle. It may as well be recognized at once that people of small or moderate incomes cannot individually budget and meet the unpredictable expenses of illness, and the insurance principle, in whatever way or ways it may be worked out, offers the greatest hope of results.

This is, of course, no revolutionary proposal. Nearly all the countries of Europe in one form or another have adopted a sickness insurance plan. We are in the fortunate position of being able to profit by the experience of our sister nations and thereby to avoid some of the errors into which they have fallen.

There is no wisdom available today which can outline with certainty a health or sickness insurance plan which would be successfully applicable to the entire United States. Conditions vary not only with the geography of the country but with the industrial conditions which are characteristic of great areas. To legislate for New England as one would for the Southwest is obviously impracticable. *And it is undoubtedly wise that experiments should be tried and that no comprehensive plan in rigid terms should be forced upon the American people by hasty edict.* As is well known, this particular problem is being brought sharply into discussion and therefore to public attention by the studies and recommendations for social security emerging from Washington. If success is to be achieved certain broad principles must permeate every plan proposed.

The first and most fundamental principle is that full cooperation between the medical and dental professions and the public is essential. Any system which would tend to lower the quality of those professions would carry the seed of ultimate failure. The control of professional procedures and the maintenance of professional standards must remain in the hands of the professions charged with responsibility. The time-honored relation between patient and physician should be safeguarded in any plan. Fortunately there is no reason why these principles should be sacrificed. The problem is clearly economic and the method of payment for service is not primarily a professional matter. In the last instance it is simply a question of the capacity of the public to pay and the method of that payment will inevitably be determined by the public which pays. There is no apparent reason why systems of sickness insurance should not be devised which would work to the advantage of both physician and patient. Indeed such are already available.

I have said nothing about one aspect of this problem which is causing grave concern in all parts of the country, and that is the critical situation in which our hospitals find themselves. Private philanthropy to which so many of them have looked for support has found itself unable longer to carry the load. It is significant that these indispensable foundations are turning to group hospital insurance to meet at least a part of the unprovided costs.

I am purposely not attempting to suggest particular and specific schemes. Different states can and should try different plans and nothing but experience will indicate the best. . . .

The task of the moment and the purpose of this series of addresses is to call the people's attention to the condition which confronts them and to urge prompt but well considered action.

**Medicine Moves Forward.**—The American Medical Association, in cooperation with the Broadcasting Company, on February 18, 1935 put out special broadcasts under the heading "Medicine Moves Forward." The speakers were Dr. Walter L. Bierring, President of the American Medical Association, Dr. Ray Lyman Wilbur, Chairman of the Council on Education and Hospitals of the American Medical Association, and Dr. W. W. Bauer, Director of the Association's Bureau of Health and Public Instruction. Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association* and of *Hygieia*, the health magazine, introduced the speakers and spoke on the subject of sickness insurance.

Dr. Fishbein stated that copies of the speeches would be available and would be sent to all who wrote to the American Medical Association, 535 North Dearborn Street, Chicago.

**British Hospital Contributory Schemes (Voluntary Health Insurance).**—Under this heading the March 1935 "Bulletin of the American College of Surgeons" prints an article by Sydney Lamb of Liverpool, England, General Secretary of the Merseyside Hospital Councils, Inc., in which is given a description of some of the voluntary hospital insurance plans now utilized by English workmen and their families. The article contains much interesting information on recent plans of voluntary sickness insurance and hospitalization, as now being carried out in some of the cities of England.

**Sickness Bills by Installment:—Wayne (Pino) County Plan.**—The March issue of the "Survey Graphic" prints an article on the "Pino Plan" for the installment payments of medical bills for services supplied by the Wayne County (Michigan) Medical Society. In the article it is stated "Health insurance lies before the states and the nation as an issue in our search for security. Detroit doctors believe they are working out a better way to get medical care for all who need it. It has been widely cited as a model . . ."

**Social Insurance Costs.**—"The Great Britain National Insurance Act began in a limited, experimental fashion in 1911 with some 2,250,000 workers. It applied only to certain trades. Amended half a dozen times to correct its imperfections it has had, almost from the first, a stormy existence. By 1931 it had rolled up a deficit of nearly two billion dollars (40,000,000 pounds) and royal commissions were sitting up nights to decide what was to be done about it."—*Saturday Evening Post*, December 15, 1934.

"The will to be well includes the willing of the means proper to that purpose, and particularly regular exercise, several hours a day in the air, good simple food taken in sufficient quantity at three regular intervals, and the avoidance of such sources of worry as will disturb physical functions."

# CALIFORNIA MEDICAL ASSOCIATION

FREDERICK C. WARNSHUIS, M. D., Associate Editor for California

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

## CALIFORNIA MEDICAL ASSOCIATION

CLARENCE G. TOLAND.....President  
ROBERT A. PEERS.....President-Elect  
FREDERICK C. WARNSHUIS.....Secretary-Treasurer and Associate Editor for California

### OFFICIAL NOTICE

**Reduced Railroad Fares to Yosemite Valley—Send for Certificate.**—Arrangements have been made for a fare and one-third for railroad travel to and from Yosemite National Park.

If you plan to travel by train, write to the State Secretary for a certificate that will authorize your local agent to sell you a ticket at reduced rates.

*You must have this certificate to obtain reduced rates.*

### MONTH'S ACTIVITIES

The Council held a two-day session in San Francisco. The minutes appear in this issue.

The Scientific Program Committee and section officers met on January 27 and completed details of the program for the annual session. Watch for the April issue, which will give the entire program.

California's seven delegates attended the special meeting of the American Medical Association House of Delegates in Chicago, February 15 and 16. A summary of action recorded will be found in this issue.

By action of the Council, notices of a special meeting of the Association's House of Delegates to be held in Los Angeles on March 2, and instructions, were sent to county officers and delegates who served at the 1934 session.

The Committee on Public Relations has held two sessions devoted to future plans of work and Fair exhibits.

The Committee of Five and their Advisory Council and technical staff held an all-day session in San Francisco on February 3, and a two-day session in Los Angeles on February 23 and 24.

By reason of the details and work required by and related to the national and state special meetings, it is impossible to fully report upon them in this issue. Complete information will be found in the April issue.

### STATE AND COUNTY SOCIETY ACTIVITIES

#### REDUCED RAILROAD FARES TO YOSEMITE

Write in to the State Secretary for identification certificates for reduced railroad rates to Yosemite National Park as per attached letter.

CALIFORNIA MEDICAL ASSOCIATION—YOSEMITE VALLEY  
May, 13-16, 1935

Your letter of January 25 regarding special fares for your convention to be held May 13-16, 1935.

For this convention, special round-trip fares to Yosemite Valley will be authorized on the identification-certificate plan on basis of 85 per cent of the current first-class one-way fare for the round trip to Merced, plus \$7.25 from Merced to Yosemite Valley.

The special round-trip convention fares will apply from all points in California except from points on the Westwood and Alturas lines of the Southern Pacific in Modoc, Plumas, and Lassen counties.

From points in California on Westwood and Alturas lines of the Southern Pacific Company the lowest available round-trip fares will be ten-day round-trip coach-

intermediate fares or the twenty-one-day summer round-trip fares.

Round-trip convention fares will be available only for members of your organization and dependent members of their families on presentation and surrender to railroad agent of an official identification certificate.

As requested, I shall arrange to forward you a supply of one thousand identification certificates. Certificates should be furnished to all delegates with names of those to whom furnished entered thereon with pen and ink (or typewriter).

The sale dates for tickets on the identification certificate plan from all points in California not involving an interstate trip will be May 9 to 16, inclusive, with return limit of May 20.

The interested rail lines would very much appreciate your advising all delegates of the very low fares offered so that as many as possible will travel via rail.

Yours very truly,

G. C. HURLESS, Agent.

Southern Pacific Building.

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### OPPORTUNITY FOR FINANCIAL LOANS

The following information, supplied by a federal representative, should be of interest to members. Those contemplating purchase of equipment, remodeling of offices, etc., will possibly avail themselves of this opportunity to secure financial assistance.

Physicians who own their own homes or lease their offices are finding useful in their profession the provisions of the National Housing Act, the legislation in back of the better housing program now in progress throughout the country.

Under this Act, doctors whose offices or laboratories are in their homes may alter, repair or modernize their suites as well as provide or replace certain equipment for experimental or treatment work, including x-ray, under the better housing plan.

Those who are leasing office space and whose lease imposes upon them the upkeep of the property, also are as eligible as actual owners, provided the lease has a duration six months longer than the repayment of the loan.

All built-in features which are permanently attached to the property come under the provisions of the Act. Refrigeration and "x-ray" equipment must be part of the permanent wiring of the building. Needless to say, plumbing, partitions, and similar fixtures come under the Federal Housing Administration plan of finance.

The National Housing Act provides an insurance reserve to banks and other lending agencies which make installment loans at a charge not greater than at the rate of five dollars a hundred a year, the fee being payable in advance. This is the lowest interest charge ever known on loans of this kind. Loans may be made up to \$2,000. Practically every bank in the country is making these loans, which usually run from one to three years.

A physician who desires to purchase permanently attached professional equipment or alterations to his property may apply to his own bank. The only requirements of the National Housing Administration are that he own the property (a mortgage in good standing is no impediment) that he expend the money for the purpose for which it was borrowed and that his income be five times the annual payments on the note. For example, to borrow \$1,500 for repayment in thirty-six months, a gross income of approximately \$2,500 per annum is required. Thus, the legal requirements are extremely simple.

These loans are, in fact, character loans. It is private money lent by your own bank and is not Government money. This is in no sense a relief or charity measure. It is intended to provide credit facilities to substantial people of good character and credit standing. The Government simply insures the loan; in other words, Uncle Sam endorses your note.

More than \$7,000 of the highest type of American citizens have made use of Federal Housing Administration loans in the first six months of its operation. Banks and other lending institutions are cooperating fully. If there is some permanently attached piece of professional equipment that you need in your practice; if your own home needs modernization to make it more comfortable for you and your family; if your personal credit standing is good, then the National Housing Act can help you. Discuss it with your bank. Loans can be made promptly by the lending institution. Applications do not have to be submitted to the Federal Housing Administration.

The modernization features of the National Housing Act automatically expire at the end of 1935. Loans made this year will, of course, run to full maturity, but no new

loans will be made after 1935 unless Congress extends the benefits of the Act. You should, therefore, investigate this now if you desire to avail yourself of these sound credit facilities provided by your Government.

\* \* \*

#### SIXTY-FOURTH ANNUAL SESSION

The April issue will contain the completed program. At this time announcement is made of some of the high-lights of the meeting.

**Out of State Guests.**—President-Elect of the American Medical Association, James S. McLester, professor of Medicine, University of Alabama, Birmingham; E. Starr Judd, Mayo Clinic, Rochester, Minnesota; George H. Whipple, dean and professor of pathology of the University of Rochester School of Medicine, Rochester, New York; and Thomas P. Sprunt of Baltimore, Maryland.

**Sunday, May 12.**—Clinico-pathologic conference, morning and afternoon.

**Monday, May 13.**—Opening general meeting, president's address; addresses by E. Starr Judd and James S. McLester. Afternoon—Symposium on the Liver, with the following speakers: George H. Whipple, Thomas P. Sprunt, William J. Kerr, Verne C. Hunt, and Douglas R. Drury. House of Delegates meets in the evening.

**Tuesday, May 14.**—Morning section meetings. Second general meeting, with the following speakers: George H. Whipple and Thomas P. Sprunt. Afternoon—No meetings. Open for sightseeing, tennis, and golf. Evening—President's dinner; fire fall, feeding the bears, and dance.

**Wednesday, May 15.**—Section meetings morning and afternoon. Third general meeting, with the following speakers: James S. McLester, Deputy Attorney-General Lionel Browne, Professor Paul A. Dodd, and Harry H. Wilson, secretary of the Committee of Five on Medical Survey. House of Delegates meets in the evening.

**Thursday, May 16.**—Section meetings morning and afternoon.

**Woman's Auxiliary.**—Officers of the Auxiliary are arranging programs for business sessions and entertainment.

**Hotels.**—The following rates have been made:

#### AMERICAN PLAN

**The Ahwahnee**—Capacity, 225. Each room with private bath.

Two in room, \$8 per person per day.

One in room, \$10 per day.

**Camp Curry**—Capacity, 1,200.

Rooms with bath:

Two in room, \$5.50 per person per day.

One in room, \$7 per day.

Rooms without bath:

Two in room, \$4 per person per day.

One in room, \$5 per day.

Tents without bath:

Two in tent, \$3.50 per person per day.

One in tent, \$4.50 per day.

#### EUROPEAN PLAN

**Yosemite Lodge**—Capacity, 300.

Rooms with bath:

Two in room, \$3 per person per day.

One in room, \$4 per day.

Rooms without bath:

Two in room, \$2 per person per day.

One in room, \$3 per day.

Members should write for their reservations.

**Railroads.**—Special sleepers will leave Los Angeles and San Francisco on Sunday night, May 12, for Merced and El Portal. See local ticket agent for reservations. Return sleepers, Thursday night.

The Yosemite will be at its best during the days of the meeting. Plan now to go and profit by the exceptional scientific program that has been arranged. Enjoy the scenery of Yosemite Park. You will be well repaid.

#### SPECIAL MEETING OF THE A. M. A. HOUSE OF DELEGATES\*

As announced in the previous issue, the House of Delegates of the American Medical Association was called in special session in Chicago on February 15 and 16, 1935. The object of this special session was to consider proposed and pending legislation related to federal and state health insurance proposals and programs.

The general summary of action recorded was sent by air mail immediately after the special meeting adjourned in order that our members may become informed as to what was transacted.

#### WORTH PONDERING OVER

"It is now, as of old, altogether probable that 'There is no new thing under the sun' in the realm of thinking. Why then should one yield to the impulsion to write and print? The answer is for the same reason that he is photographed or done in oils or marble, namely, in the hope to escape oblivion."

\* \* \*

The dean of St. Paul's, in London, addressed a group of visiting doctors from all over the world in these words: "I greet you as defeated captains. You are always doomed to final failures in your encounters with disease."

The comment has been made that it is true enough, but we are meeting the enemy more successfully than ever before in history, and though still doomed to final failure, that finale is being put off longer and longer by reason of our greater knowledge.

\* \* \*

The chemical humorist, Clowson, says: While sound travels at a speed of 11,000 feet per second, it often takes about twenty years to penetrate through the ear to the brain.

\* \* \*

Texans relate the following as being their method of serving planked jack rabbit. "After parboiling the rabbit and the plank, with repeated changes of water, for a day or two, and then baking what is left for another day, the wise Texan throws the rabbit away and eats the plank."

Of the many plans advanced for social security, possibly we can parboil and bake them all on one plank, and eventually eat the plank—at least we can experiment by controlled provisions, and satisfactorily solve the whole problem.

\* \* \*

"California Board of Professional Instructors of Golf." Cheer up, you golfers in the 100-and-up class. If Senate Bill 562 is passed you will be able to find a certified "Pro," possessed of these qualifications: eighth-grade graduate, moral temper, fit to instruct and familiar with implements used in golf. Don't patronize unlicensed "prof."

\* \* \*

"Benjamin Franklin's adage, right a hundred and fifty years ago, is just as true today. For sleep, which takes away the tired feeling that results from the strain of modern life, does bring vitality, money and knowledge. To those of us who want a more appealing personality, sleep will bring much of the energy that gives it. Because, as tiredness changes character profoundly, it is difficult for the under-rested man or woman to have pleasing personality traits. Schopenhauer, having slept enough, might have written an optimistic philosophy."

\* \* \*

"Modern medicine gives more attention to diet than to almost any other single factor in the control of the human body. The appetite is a fairly good guide to the time when eating should be indulged in and the quantity to be taken. It is a good rule to stop just short of satisfaction. An epicure or gourmand is hardly likely to stop at this point."

\* Editor's Note.—Resolutions adopted by the House of Delegates of the American Medical Association are printed on page 207.

## COUNCIL MINUTES

## Minutes of the Two Hundred and Thirtieth Meeting of the Council of the California Medical Association

*The following minutes were approved by the Council at its two hundred and thirty-first meeting, held at Los Angeles, Saturday, March 2, 1935.*

Held in Room 210, Sir Francis Drake Hotel, Saturday, January 19, 1935, at 9:30 a. m.

**Present.**—Doctors C. G. Toland, president; Robert A. Peers, president-elect; E. M. Palette, speaker; T. H. Kelly, chairman of Council; Karl L. Schaupp, chairman of Executive Committee; Councilors W. W. Roblee, H. J. Ullmann, F. R. DeLappe, A. L. Phillips, C. E. Schoff, H. S. Rogers, Harry H. Wilson, C. O. Tanner, W. H. Kiger, M. R. Gibbons; C. A. Dukes, chairman of Public Relations; George H. Kress, editor; F. C. Warnshuis, secretary; and Hartley F. Peart, general counsel.

**Absent.**—Doctors Carl L. Howson, O. D. Hamlin, J. B. Harris.

1. **Call to Order.**—The meeting was called to order by the chairman, T. Henshaw Kelly.

2. **Minutes of the Council.**—Secretary presented minutes of the adjourned two hundred and twenty-ninth meeting of the Council held on December 22, 1935.

Moved by Councilor Roblee, seconded by Councilor Phillips, that the minutes of the adjourned two hundred and twenty-ninth meeting of the Council be approved. Carried.

3. **Corporate Practice.**—Chairman Kelly read "An Act for the Regulation and Control of Corporations Organized for the Purpose of Operating Non-Profit Hospital Service Plans" as prepared by the San Francisco and Southern Hospital Conferences and Legislative Committee of the Western Hospital Association.

Moved by Speaker Palette, seconded by Councilor DeLappe, that the proposed act for control of corporations operating non-profit hospital service plans be referred to the Committee on Public Relations with the request that they report back to the Executive Committee, which shall have power to act. Carried.

4. **San Diego Health Insurance Program.**—Secretary presented the plan of the San Diego County Society for health insurance under a fraternal benefit society.

Moved by President Toland, seconded by Councilor Ullmann, that the San Diego medical service plan be referred to the Committee on Public Relations with instructions to report to the Executive Committee. Carried.

5. **Philip King Brown Correspondence.**—Correspondence between P. K. Brown, the chairman, and the secretary was read to the Council.

Moved by Councilor Roblee, seconded by Councilor Schaupp, that the reply of the chairman be approved. Carried.

Moved by Chairman of Public Relations Dukes, seconded by Councilor Phillips, that in regard to the insurance practice of the Los Angeles County Medical Association, Doctor Brown be sent a copy of the Los Angeles County Medical Association Bulletin of June 18, 1931, which contains the arrangement between the Los Angeles Association and the Metropolitan Water District, and that he be further informed that the Council will be glad if he will submit any further criticism that he may have either by letter or in person. Carried.

6. **Committee of Five.**—Chairman Kelly stated the time set for the report of the Committee of Five had arrived.

Moved by Chairman of Public Relations Dukes, seconded by Speaker Palette, that the Committee of Five be invited to submit the reports of the individual members and the committee and that no discussion be had at this time. Carried.

Dr. Charles Sweet, president of the Northern California Dental Association, sat with the Council, representing dentistry.

Professor Paul Dodd, Director of Survey, presented the preliminary report of the survey and outlined the facts contained therein. Doctor Dodd stated that the staff of the survey was not ready to make recommendations on the basis of the incomplete data contained in the preliminary report with the exception of urging that hasty legislation be not enacted.

A. R. Kilgore presented and discussed tentative principles of any compulsory or voluntary health plans submitted by the Committee of Five for discussion by the Council. Doctor Wilson suggested that the principles be submitted to the Council for consideration.

Doctor Yoell then addressed the Council asking that consideration be given to a compulsory health insurance bill he was having prepared instead of to the principles submitted by the committee. Doctors Wilson and Peers discussed the principles submitted by the committee.

7. **Noon Recess.**—At this point, on motion of Councilor Ullmann, seconded by Speaker Palette, the Council recessed until 2 p. m. for luncheon.

8. **Coffey Correspondence.**—Correspondence from Walter B. Coffey relative to replies to inquiries received at the State office requesting information on the Coffey-Humber cancer extract, was read.

Moved by Councilor Gibbons, seconded by Wilson, that the Council inform Doctor Coffey that the secretary acted under Council instructions. Carried.

Further discussion was had by members of the Council, including Doctor Dukes, the chairman of the Cancer Commission.

Moved by Councilor Wilson, seconded by Councilor Gibbons, that the reply to Doctor Coffey include the action embodied in Doctor Gibbons' motion and the thoughts expressed by Doctor Dukes, and that the letter be signed by the chairman of the Council by order of the Council, and that the letter, before being signed, shall be approved by Doctors Gibbons and Schaupp. Carried.

9. **Illness of Doctor Hamlin.**—A message telling of the illness of Doctor Hamlin was presented and Councilor Ullman moved, seconded by Councilor Gibbons, that a telegram expressing the good wishes of the Council be sent Doctor Hamlin by Chairman Kelly.

10. **Qualifications Act.**—Editor Kress presented a revision of the proposed Qualifications Act.

Moved by Editor Kress, seconded by President Toland, that with the assistance of Doctors Gibbons, Magan, Harris, Kelly, Toland, Peers, Warnshuis, and Mr. Peart, the bill be revised and presented to the Executive Committee for consideration and power to act.

11. **Hoffman Articles.**—Editor Kress brought up the question of continuation of publication in the JOURNAL of the uncompleted series of health insurance articles by Mr. Hoffman.

Moved by Councilor Roblee, seconded by Councilor Ullmann, that publication of the articles of Mr. Hoffman be continued in the JOURNAL. Carried.

12. **Amendments to Medical Practice Act.**—Proposed amendments to medical practice act were discussed.

Moved by Editor Kress, seconded by Councilor Phillips, that the Association cooperate with the State Board of Medical Examiners in regard to legislation of medical interest. Carried.

13. **Survey of Legal Expense.**—Councilor Roblee, chairman of the Special Committee on Survey of Legal Expense, reported progress and stated that a report would be presented at the next meeting of the Council.

14. **Malpractice Insurance.**—Discussion of malpractice insurance was deferred until the next meeting of the Council.

15. **County Charters.**—General Counsel Peart brought up the matter of incorporation of provisions in County Charters to provide for legal use of county-hospitals. The matter was left to the discretion of Councilor Kelly and Mr. Peart.

16. **Disciplinary Procedures.**—The General Counsel presented tentative rules to govern disciplinary procedures in county societies to be included in by-laws.

Moved by President-elect Peers, seconded by Chairman Public Relations Dukes, that the by-laws governing disciplinary procedures in county societies be left to the approval of Doctors Toland, Kelly and Warnshuis. Carried.

17. **Commitment Laws.**—General Counsel Peart stated that commitment laws as suggested by George G. Hunter should be reviewed and their introduction into the legislature considered.

Moved by Councilor Tanner, seconded by Councilor Phillips, that the commitment laws be reviewed and if previous supporters are still in favor thereof that they be introduced into the 1935 legislature. Carried.

18. **Collection of Fees in Judgment Cases.**—General Counsel Peart presented correspondence regarding proposed legislation governing the matter of collection of hospital and doctor bills after settlement of a claim of a minor against one causing personal injury to the minor for which the minor was admitted to the hospital, by amendment of Section 372 of the Code of Civil Procedure.

Moved by Councilor Ullmann, seconded by Councilor Rogers that legislation providing for collection of hospital and doctors' fees where judgments are rendered, be introduced at this legislative session. Carried.

19. **Francis vs. Nelson.**—General Counsel Peart reported on the present status of the case of Francis vs. Nelson, stating that he had advised the attorneys that it was impossible to correct or pass upon his brief until a transcript of testimony was received.

20. **Pacific Employees' Insurance Company vs. Insurance Commissioner.**—General Counsel Peart reported on the present status of the case of Pacific Employers Insurance Company vs. Insurance Commissioner Mitchell.

21. **Goodale vs. Brite.**—General Counsel Peart presented a report upon this case.

Moved by Councilor Ullmann, supported by Councilor DeLappe, that the County Hospital Bill as suggested by Counsel Peart, be introduced in the form as was finally amended in the 1933 legislature. Carried.

22. **Laboratory Bill.**—General Counsel Peart pursuant to instructions presented a proposed bill to govern clinical laboratories and suggested that the bill be introduced. Moved by Councilor Ullmann, seconded by Councilor Dukes, that the bill be introduced. Carried.

23. **Corporate Practice of Professions.**—General Counsel Peart presented proposed Anti-Corporate Practice Bills.

Moved by Councilor Ullmann, seconded by Editor Kress, that the bill be approved. Carried.

24. **Amendments to Medical Practice Act.**—Copies of proposed amendments to the Medical Practice Act contained in Doctor Pinkham's letter of January 16 were ordered sent to all councilors.

25. **Legislative Committees.**—Secretary presented a list of the committees appointed at the present legislative sessions.

26. **Board of Institutions.**—Letter regarding the Board of Institutions was read for the information of the Council.

27. **Clinic Bill.**—The ineffectiveness of the present Clinic Bill because of lack of funds for enforcement was discussed and it was suggested that an amendment be introduced increasing the licensing fee.

Moved by Councilor Kiger, seconded by Vice-President Peers, that the Clinic Law be amended to provide for effective control. Carried.

28. **Auditors Report—Budget.**—Chairman of the Auditing Committee Schapp presented the Report of the Auditors on the funds and accounts of the Association.

Moved by Councilor Schapp, seconded by Councilor Gibbons, that the Auditors' Report be approved.

A report on revision of printing costs of the JOURNAL was submitted and it was stated that a report would

be submitted at the next meeting of the Executive Committee.

Moved by Councilor Ullmann, seconded by Chairman of Public Relations Dukes, that the budget report as submitted by the Executive Committee be received and placed on the docket for the next meeting of the Council.

29. **Advertising Contract.**—Doctor Wilson stated that he had contacted Mr. Guttman and it was agreeable to him to terminate the present advertising contract without awaiting for the six months' notice of termination period to elapse.

Moved by Editor Kress, seconded by Chairman of Public Relations Dukes, that the whole matter of arrangements for termination of Mr. Guttman's advertising contract be left in the hands of Doctor Wilson. Carried.

30. **Meeting of House of Delegates.**—Moved by Councilor Roblee, seconded by Councilor Phillips, that the following resolution be adopted:

WHEREAS, Pending and proposed federal and state legislation related to medical care and medical services makes it imperative for the California Medical Association to formulate principles and policies that will declare its position in regard to such legislation; therefore, be it

*Resolved*, That the Council of the California Medical Association under provisions stated in Article IX, Section 5, of the Constitution, direct the Association secretary to issue a call for a special meeting of the House of Delegates to convene at 1 p. m. on the second day of March, 1935, in the City of Los Angeles at the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, and be it

*Resolved*, That the object of such special meeting shall be:

(a) To receive and consider the report of the Committee of Five and to take such action thereon and to formulate such principles and policies in regard to health insurance medical services and medical care as the judgment and wisdom of the delegates may determine to be for the best interests of the public and the members of the Association;

(b) To transact such other business of the Association as may be transmitted to the House of Delegates by the Council of the Association; and be it

*Resolved*, That the order of business shall be as follows:

1. Call to order.
2. Report of Credentials Committee.
3. Roll call of delegates.
4. Reading of the call.
5. Report of the Committee of Five.
6. Council communications.
7. Resolutions.
8. Reference Committee, Report of.
9. Adjournment.

Unanimously carried.

31. **Conference With Interim Committee.**—Moved by Councilor Schapp, seconded by Councilor Gibbons, that the representatives of the Council at the conference with the Senate Interim Committee, to be held in Sacramento, January 20, 1935, be the president, the president-elect, the speaker, the chairman of the Council, the secretary of the Committee of Five, and that Professor Dodd and General Counsel Peart be asked to accompany these representatives to Sacramento. Carried.

32. **Council Meeting.**—Moved by President Toland, seconded by Councilor Ullmann that the next meeting of the Council be held in the Los Angeles County Medical Association Building, Saturday, March 1, 1935, at 9 a. m. Carried.

33. **Adjournment.**—On motion of Councilor Gibbons, seconded by Councilor Kiger, the meeting adjourned at 5:15 p. m.

T. HENSHAW KELLY, Chairman.  
F. C. WARNSHUIS, Secretary.

### Minutes of the Two Hundred and Twentieth Meeting of the Executive Committee of the California Medical Association

Held in the offices of the California Medical Association, Room 2004, 450 Sutter Street, San Francisco, Friday, January 18, 1935, at 4:30 p. m.

**Present.**—Clarence G. Toland, president; Robert A. Peers, president-elect; T. Henshaw Kelly, chairman of the Council; Edward M. Pallette, Speaker; Karl L. Schaupp, chairman of Executive Committee; Charles A. Dukes, chairman of Public Relations Committee; George H. Kress, editor; F. C. Warnshuis, secretary; Hartley F. Peart, general counsel.

**Absent.**—None.

1. **Call to Order.**—The meeting was called to order by the chairman of the committee, Karl L. Schaupp.

2. **Ivy Exhibit.**—Secretary reported on rental of store space at Sacramento for Ivy Exhibit.

Moved by Editor Kress, seconded by chairman of Public Relations Dukes, that a special committee consisting of Doctors Peers and Schoff be authorized to make such arrangements as in their judgment they deem best, at a cost of not to exceed \$100. Carried.

3. **Narcotic Committee.**—Secretary reported on meeting of Narcotic Committee on December 28, 1935, for which Chairman Kelly had appointed Doctors Catton and Warshuis to represent the California Medical Association.

Moved by Councilor Gibbons, seconded by President Toland that the membership of the Special Committee on Narcotic Problems be approved and that the committee be empowered to represent the Association at future conferences. Carried.

4. **Advertising Contract.**—Secretary reported on advertising contract of Mr. Guttman.

Moved by Editor Kress, seconded by chairman of Public Relations Dukes, that the whole matter be left in the hands of Doctor Wilson. Carried.

5. **Advertising Commissions.**—Secretary reported on Association's policy of paying commissions when advertisement is inserted in JOURNAL in lieu of waiting until actual cash payment is made. Secretary also reported on uncollectible accounts now on books.

Moved by Editor Kress, seconded by chairman of Public Relations Dukes, that the recommendations of the secretary be approved and that no commissions be paid on advertising contracts until actual cash payment is received and that the secretary-treasurer be authorized to place "uncollectible accounts" in the hands of collection agencies and prepare a list of accounts where the institution of suits are recommended and that the latter accounts be submitted to the Council or Executive Committee for approval before final action is taken. Carried.

6. **Utah Medical Survey.**—Secretary presented the report of the Utah Medical Survey.

On motion of chairman of Public Relations Dukes, seconded by Councilor Kelly, the report was referred to the editor. Carried.

7. **SERA.**—Secretary reported that at present there was no SERA administrator and until such appointment was made matters would be at a standstill.

Doctors Peers and Toland were instructed to send correspondence regarding status of SERA to state secretary for insertion in the "Correspondence Column" with secretary's comments.

8. **Communication from San Francisco Society.**—A communication from the San Francisco County Medical Society regarding a dangerous drug was read by the secretary.

On motion of chairman of Public Relations Dukes, supported by Councilor Peers, the communication was referred to the Bureau of Pharmacy and Chemistry of the American Medical Association with request for information on legislation that may have been inaugurated in other states from a medical standpoint and from a legal standpoint, and that the secretary be requested to send copies thereof to the State Board

of Health and submit a report to the Council or Executive Committee for further consideration and action. Carried.

9. **Disciplinary Procedure.**—Secretary presented letter from Doctor Molony regarding disciplinary procedure in constituent county societies. The secretary was instructed to reply to Doctor Molony.

10. **Unethical Advertising.**—Editor Kress brought up the question of unethical advertising as carried on by certain physicians and the need of legislation covering same, stating that this could be covered by an amendment to the Medical Practice Act.

11. **Auditor's Report.**—The secretary read the report of the Certified Public Accountants, Ernst & Ernst, on Association funds.

On motion of Kelly, seconded by Kress, the committee recommended that the Council adopt the Auditor's Report and pay the cost thereof. Carried.

It was ordered that the recommendations attached to the Auditor's Report be turned over to the Auditing Committee for study and report.

12. **Budget.**—Secretary read the proposed Budget of Receipts and Expenses for 1936, which was approved for consideration by the Council.

13. **Publication of Journal.**—Editor Kress and Secretary Warnshuis presented reports on publication costs of CALIFORNIA AND WESTERN MEDICINE.

Moved by Speaker Pallette, seconded by President-elect Peers, that a Committee of Three, consisting of the secretary, the chairman of the Council and the editor be requested to take this up with the James H. Barry Company and report back to the committee.

14. **X-Ray Acts.**—Various proposed x-ray bills were called to the attention of the committee and the general counsel reported that he would submit a tentative draft which would provide for control of clinical laboratories by State Board of Health.

15. **Adjournment.**—There being no further business the meeting adjourned.

KARL L. SCHAUPP, *Chairman.*  
F. C. WARNSHUIS, *Secretary.*

### COMPONENT COUNTY MEDICAL SOCIETIES

#### CONTRA COSTA COUNTY

The regular monthly meeting of the Contra Costa County Medical Society was held on Tuesday evening, February 12, at the Nurses' Home of the County Hospital, Martinez.

The meeting was called to order by Dr. W. S. Lucas, who introduced Mr. T. H. DeLap of Richmond, Assemblyman to the State Legislature from this district. Mr. DeLap spoke most interestingly and informingly of the legislation pending before the State Senate and the State Assembly, with especial reference to those eighty bills which will have a bearing, either direct or indirect, upon the medical profession.

Doctor Lucas called upon Dr. E. W. Merrithew, who was chairman of the evening, to introduce Doctor Reynolds of San Francisco, who had graciously accepted the invitation to be speaker of the evening. Doctor Reynolds gave a splendid paper on the various manifestations of the *Endocrine Dyscrasias*.

Doctor Ford, as chairman of the Committee on Public Relations and Legislation, expressed his appreciation to Mr. DeLap, and sounded a word of warning that every member become legislation conscious.

Application for membership in the Society was presented by the secretary from Dr. Walter Taylor of Martinez. Motion that he be accepted was made by Doctor Weil, seconded by Doctor Sweetser, and carried.

Doctor Lucas announced the meeting place for the March meeting as Richmond, with Dr. J. B. Spalding as chairman; for April, in Richmond, with Dr. L. Abbott Hedges as chairman; and for May our custom-

ary dinner meeting at Pittsburg, with Doctors Kerns and Marks acting as committee in charge.

Doctor Beard presented some tentative figures of industrial fee schedule which might be incorporated in a possible fee schedule for part-pay patients. The matter was referred to Dr. Harry Ford, chairman of the Committee on Public Relations.

The attendance was gratifyingly large—twenty-six.

CLARA H. SPALDING, *Secretary*.

#### HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of January 26 at St. Joseph's Hospital, Dr. Charles C. Falk, Jr., presiding. Twenty-four members and sixteen nurses were present.

The guests from San Francisco were Doctors R. C. Martin, Laurence Taussig, and Howard Morrow.

Committees were appointed on Program, Public Relations, Public Health, Legislation, Education, Membership, and Entertainment.

The main feature of the evening were the papers by the visitors—*Sinusitis, Etiology and Treatment* by Dr. R. C. Martin; *Ringworm and Athlete's Foot* by Dr. Laurence Taussig. Dr. Howard Morrow, in his jovial manner, gave us what he termed "easy," *Epithelium of the Mucous Membranes and Their Treatment*. Many slides were used in these discussions.

The Society and visitors received a great deal from these papers and expressed many thanks to the doctors for making the long trip.

LAWRENCE A. WING, *Secretary*.

#### KERN COUNTY

The regular January meeting of the Kern County Medical Society was held at the Padre Hotel, Thursday evening, the 17th.

With the approval of the board of directors, President Strongin appointed the following committees:

*On Admissions*—Doctors Gundry, Schaper, Moore. *On Professional Conduct*—Doctors Buchner, Packard, Moodie. *On Grievances*—Doctors Compton, Goodall, William B. Smith. *On Programs*—Doctor Packard, Moore, McLain. *On Publications*—Doctors Compton, Garner, Cuneo. *On Hospitals and Dispensaries*—Doctors Root, Cuneo, Lange. *On History and Obituaries*—Doctors Veon, Buchner, Morris.

Following the business meeting Dr. F. M. Pottenger of Monrovia gave a talk on pulmonary tuberculosis, stressing particularly the importance of early diagnosis.

L. H. Fox, *Secretary*.

#### MENDOCINO COUNTY

The first regular meeting of the year of the Mendocino County Medical Society was held on February 14 at the Palace Hotel, in Ukiah. Dinner was served at 7 p. m. for members, their ladies, and guests. Members present were: Doctors Babcock, Bowman, Bennett, Cushman, Cleland, Hill, Hummel, Kirwin, Pinto, Le Baron, Toller, and Wrinkle. Guests present were: Doctors C. Abbott, G. K. Abbott, M. A. Craig, Lloyd Johnstone, Petty, and Starbuck.

After the dinner the meeting was called to order by Doctor Bowman.

The applications of Doctors Charles W. Leach of Kelseyville, Charles A. Craig of Lakeport, and G. K. Abbott of Ukiah for membership into the Society were read and accepted. A report of new bills before the legislature was read by Doctor Kirwin. Doctor Cushman reported on a purpose of the special meeting of the House of Delegates.

As this was the first regular meeting of the year, election of officers was held. Dr. R. B. Toller of Talmage was elected president; Dr. H. O. Cleland of

Ukiah, alternate delegate; Dr. J. J. Kirwin of Ukiah, secretary-treasurer.

The next meeting will be held early in May in Lake County.

R. B. TOLLER.

#### ORANGE COUNTY

The regular monthly meeting of the Orange County Medical Association was held February 5 in the chapel of the Orange County Hospital, with our new president, Doctor Hawes, presiding.

After the customary business session the obituary of Dr. Clarence A. Neighbors was read.

Doctors F. J. Gobar of Fullerton and J. P. Boyd of Santa Ana, the latter a charter member of this Association, now in its forty-seventh year, were unanimously voted to honorary membership.

Dr. A. R. Roos of Loma Linda gave an enlightening and open-minded discussion and demonstration of *Bacteriophage in Septicemia*. Dr. Donald Abbott of the Orange County Hospital gave a concise history of the use of bacteriophage in septicemia due to *Staphylococcus aureus*, on one of the hospital doctors, with more than hoped-for results.

WALDO S. WEHRLY, *Secretary*.

#### SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, February 5. The meeting was opened by the President at 8 p. m. About sixty members and guests were present.

The following applications for membership were approved: Doctors E. A. Sommer, M. Antoinette Benette, James W. Moreland, John Boyd Tyrrell, Mary E. Beall, Harry S. Blossom, Darrell E. Hayhurst and Pearl S. Waters, and Clement C. Counter by transfer from Orange County.

Dr. C. G. Hilliard, chairman of the SERA Medical Advisory Committee, explained that a difficulty had arisen at Twenty-nine Palms, in that Dr. W. A. Nicholson had done the CWA work for that area and now the SERA work, under the committee's impression that he was a physician. Recently an osteopath, Doctor Parker, also requested to do the work and when refused stated that Doctor Nicholson was an osteopath. The suggestion was made that it would be possible for the SERA workers in the Twenty-nine Palms district to be given extra work to pay these doctors directly and thus not conflict with the rules of the present medical program. Dr. F. E. Clough stated that the American Legion is endeavoring to have a physician at Twenty-nine Palms for the proper care of the people of that district, and that if and when a medical man was located there he could do the SERA work. It was moved and seconded that the plan suggested by Doctor Hilliard be used until such time as a medical man be located at Twenty-nine Palms. Passed.

Dr. C. G. Hilliard gave a short obituary on the late Doctors George Weger and E. J. Eytinge, following which, at Doctor Hilliard's suggestion, the whole Society stood in silence for a few seconds.

The secretary was asked to read the following resolutions, drawn up by a committee composed of Doctors Dole and Walton, to be spread upon the minutes of the Society, and a copy sent to the bereaved families.

#### IN MEMORIAM—ERNEST J. EYTINGE

WHEREAS, It has pleased the Almighty God to take from our midst our beloved and highly respected colleague, Dr. Ernest J. Eytinge; and

WHEREAS, This Society feels most deeply the loss of one who wisely guided its policies through many years of active development and progress; therefore be it

*Resolved*, That the San Bernardino County Medical Society extend to the bereaved family this expression of its deep sorrow and most sincere and heartfelt sympathy.

IN MEMORIAM—GEORGE S. WEGER

WHEREAS, It has pleased the Almighty God to take from our midst our beloved and highly respected colleague, Dr. George S. Weger; and

WHEREAS, This Society feels most deeply the loss of one who has been a member for many years; now therefore be it

*Resolved*, That the San Bernardino County Medical Society extend to the bereaved family this expression of its deep sorrow and most sincere and heartfelt sympathy.

The president read the following list of names—Doctors Dole, Gage, Hilliard, Hill, and Mock—which had been selected and approved by the Council to be sent to Supervisor Porch, from which he might choose a successor to the late Dr. E. J. Eytinge on the Medical Advisory Board to the County Hospital.

It was moved and seconded that the secretary send the above list of names to Mr. Porch. Passed.

The program of the evening was then given: *Case Report*, Dr. Walter Cherry; *Sickness Insurance*, Dr. Harry H. Wilson, president, Los Angeles County Medical Society; *Pending State Legislation Affecting Medicine*, Mr. Ben Read, secretary, Public Health League of California; *Modern Methods of Anesthesia* (motion pictures), Dr. A. D. Neubert.

A. E. VARDEN, *Secretary*.

#### SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held in the clubrooms of the Medico-Dental Building, Stockton, at 8:15 p. m. President C. A. Broaddus presided.

The regular meeting was preceded by a supper session held at the Hotel Clark at 6:15 o'clock, this supper being an innovation. It was very well attended, there being twenty-three persons, including four guests. A paper was presented at this meeting by Dr. A. L. Van Meter and Doctor Bawden, professor of chemistry, College of the Pacific, on *Medical and Chemical Tests for Inebriation*. This paper was accompanied by chemical demonstrations. It was very instructive and created considerable discussion.

The minutes of the preceding meeting and of two board of directors' meetings were read.

Dr. Dewey Powell gave a report on the coming meeting of the House of Delegates to be held in March.

The program for the evening was: *A Symposium on Bone Tumors*. Dr. C. S. Connor, professor of pathology, University of California, spoke on pathology. Dr. H. E. Ruggles, roentgenologist, University of California, spoke on the radiologic aspect of bone tumors, and Dr. E. I. Bartlett, associate professor of surgical pathology, University of California, spoke on the clinical and therapeutic aspect of these conditions. The papers were illustrated by means of lantern slides and pathological specimens. It was a very instructive presentation of the subject. The program was discussed by Doctors McGurk, Hull, Dozier, and C. V. Thompson, the discussion being closed by the guest speakers.

President Broaddus announced the next meeting would be *A Symposium on Tuberculosis*. He also announced there would be a board of directors meeting in the clubrooms at 5 p. m. Wednesday, February 13. He then brought up the subject of the University of California postgraduate session and the possibility of bringing this service to Stockton. Doctor Van Meter moved that a committee be appointed to investigate

the establishment of this course at Stockton. This was seconded by J. P. Hull. The motion was carried.

The meeting was adjourned at 10:26 o'clock and refreshments were served.

G. H. ROHRBACHER, *Secretary*.

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#### SAN LUIS OBISPO

REPORT OF THE SAN LUIS OBISPO COUNTY MEDICAL SOCIETY FOR THE YEAR 1934

President, Jens W. Larsen, Paso Robles.

Vice-President, L. T. Wade, San Luis Obispo.

Secretary-Treasurer, A. F. Gillihan, San Luis Obispo.

Speakers of interest provided constructive programs throughout the year. These included the following:

Dudley Smith of San Francisco—*Surgical Conditions of the Rectum and Colon*.

G. K. Rhodes and Fred H. Kruse of San Francisco—*Medical and Surgical Treatment of Peptic Ulcer*.

G. W. Pierce of San Francisco—*Burns and Their Treatment*.

Hugh Jones of Los Angeles—*Treatment of Fractures*.

Karl Meyer, Ph. D., San Francisco—*The Rise and Fall of Epidemics*.

Vern Hunt of Los Angeles—*Malignant Tumors of the Colon and Intestinal Obstruction*.

Sterling Bunnell of San Francisco—*Fractures of the Hip*.

Eric Larsen of Los Angeles—*Thyroid Disease: Differentiating between the Different Types*.

R. W. Langley of Los Angeles—*Thyroid in Heart Disease*.

Adolph Kutzmann of Los Angeles—*Lesions of the Urinary Tract*.

S. R. Mettier of San Francisco—*Classification of Anemias in General*.

E. Falconer of San Francisco—*Treatment of Secondary Anemias*.

A San Luis Obispo County branch of the Public Health League was organized in June and aided materially in defeating the proposed Chiropractic and Naturopathic measures in this county.

Speakers from the Society were provided for various clubs, bureaus and other organizations desiring ethical medical information on current topics.

The Society cooperated with the Parent-Teacher Association in securing more efficient treatment of the semi-indigents.

The officers elected for the year 1935 are as follows: President, C. J. Teass of San Luis Obispo; vice-president, G. D. Kelker of San Luis Obispo; secretary-treasurer, A. F. Gillihan of San Luis Obispo.

Preceding the election of new officers, a dinner and dance for the members of the Society, their wives, and guests was held at the Hotel Paso Robles.

ALLEN F. GILLIHAN, *Secretary*.

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#### SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara Medical Society was held in the Bissell Auditorium of the Cottage Hospital on February 11, with President Shelton presiding.

The minutes of the organization meeting of the Council were read and the recommendations contained therein were adopted and attached to the minutes as part of this meeting.

Doctor Gray then reported for the Committee on the Costs of Medical Care, and a proposed letter to Mr. Perkins of the Community Chest was read.

Upon balloting, Dr. George V. Hamilton was elected to active membership of the Society and Dr. George W. Jean was elected to retired membership.

The speaker of the evening, Dr. John C. Irwin of Los Angeles, was introduced by Doctor Shelton.

Doctor Irwin's paper on *Cesarean Section*, with motion pictures showing the various steps of the operation, was extremely interesting and instructive, and was discussed by Doctors Loveren, Johnson, and L. Eder.

WILLIAM H. EATON, *Secretary*.

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#### SISKIYOU COUNTY

The meeting of the Siskiyou County Medical Society was held at the Yreka General Hospital, with Dr. J. R. U. Campbell presiding. The SERA work was discussed, and members are awaiting the uniform schedule to be drawn up before putting their names on the panel of that association.

The formation of a unit in the Auxiliary to the Society was discussed, as a means of stimulating more interest in the meetings. After the women have been consulted, it is hoped further steps will be taken.

The information that Doctor Warnshuis, our Association Secretary, might be paying us a visit was received with much pleasure. It is hoped that he will be in Weed on March 24 for our next meeting.

The Epstein Bill and other forms of health insurance without medical supervision were condemned.

As most of the snow has melted and the day was warm, the current meeting was poorly attended. One member even walked out on us to play golf.

LESLIE J. SEELEY, *Secretary*.

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#### SOLANO COUNTY

The Solano County Medical Society held its regular monthly meeting on Tuesday, February 12. The meeting was well attended, there being about fifty present.

Dr. William Kerr of the University of California Hospital was the guest speaker of the evening, and his topic was *Coronary Vascular Disease*. The talk was exceptionally interesting. A. E. CHAPPELL, *Secretary*.

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#### TULARE COUNTY

The first meeting of the Tulare County Medical Society for 1935 was held at Motley's Cafe, Sunday evening, January 27, at 6:30 o'clock. Dinner preceded the program.

The officers for 1935 formally assumed their rôles. Dr. Ray Rosson, president-elect, opened the meeting. The Society had as guests, Doctor DeLappe, councilor of the fourth district; Doctors D. G. Morton and H. G. Watson, speakers of the evening; Dr. Leonard Lipson, dentist; and Mr. Masterman, representing Meade Johnson. Dr. Ray Cronemiller of Exeter was introduced to the Society as an applicant for membership.

The financial report for 1934-1935 was reviewed and approved.

Doctor Zumwalt, Tulare County Health Officer, requested more accurate reporting of communicable diseases.

Doctor Fillmore asked that the Society devote a portion of its program to case reports and discussions. This matter was referred to the Committee on Education.

The following committees were appointed by Doctor Rosson to serve during 1935:

*Committee on Physical Therapy*—Edgar Brigham (chairman), J. C. McClure. *Committee on Education*—Frank Kohn (chairman), Philip S. Barber, Gilbert B. Furness, S. S. Ginsberg, W. B. Parkinson, K. F. Weiss. *Committee on Public Relations*—W. W. Tourtillott (chairman), Frank Guido, E. R. Zumwalt. *Committee on Membership*—A. W. Preston (chairman), H. G. Campbell, R. C. Hill, S. Rogers, N. Miller, P. Miller. *Committee on History and Obituaries*—Austin V. Miller (chairman), J. E. Beck. *Medical Milk Commission*—E. R. Zumwalt (chairman), Ray Cronemiller, Karl F. Weiss.

Doctor DeLappe submitted his report of the Council's activities for the past year. The coming California Medical Association meeting at Yosemite, May 13 to 16 inclusive, was brought to our attention. Health insurance plans are soon to be formulated, and our Society was urged to definitely instruct our delegate as to our attitude locally when the committee meets.

The educational program followed. Our first speaker was Dr. Daniel G. Morton of the University of California, who read a paper on *Breech Presentations*. The paper was clarified by lantern slides. Dr. H. G. Watson, obstetrician from San Francisco, next presented *An Outline of Prenatal and Postnatal Care in the Management of Normal Obstetrics*. A general discussion followed.

Though a rather lengthy meeting resulted, a majority of the members remained to see several films shown through the courtesy of Mr. F. A. Masterman, Mead Johnson & Company representative. One was on *Fertilization and Ovulation in the Female* and another, *Breech Extraction*.

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The February meeting of the Tulare County Medical Society was held at Motley's Cafe Visalia, Sunday evening, February 17.

The Society had as guests, Doctors J. S. Glenn and Davis of Visalia, Doctors Winn and Smith of Springville, and Dr. C. W. Dodge, guest speaker of the evening.

A motion was made by Doctor Betts, seconded by Doctor Hill, to admit Dr. Ray Cronemiller to the Society. Doctor Cronemiller was elected by unanimous vote. An application for membership was also read from Doctor Winn of Springville.

It was with regret that we heard of Doctor Zumwalt's fractured arm.

Doctor Rosson introduced Dr. C. W. Dodge of the Veterans' Administration Facility, who is chief of the tuberculosis unit in San Francisco. His subject dealt with the United States Government's care of ex-service men with regard to medical care and hospitalization. His remarks were prefaced with an interesting historical account of military pensions from their inception to the present time. A number of questions regarding the care of veterans by the local doctors were answered. This talk helped considerably to clarify our ideas as to the nature of services rendered.

The remainder of the evening was devoted to a general discussion of the subject of health insurance. Dr. I. H. Betts, chairman of the Committee on Economics, reported the recommendations of his Committee on Health Insurance as follows: It was felt that some type of action is necessary if there is a change from the present system. In the event of organization of plans for a form of health insurance it is the committee's feeling that it be medically planned and controlled as far as possible; that medical monopolies should be prevented; that the plan should provide some regulation of qualification so that adequate medical attention can be offered and that compensation should be on a fee basis.

Members present expressed their opinions variously. A motion was made by Doctor Hill that our delegate be instructed to use his own discretion at the special meeting, keeping in mind the opinions as expressed here.

KARL F. WEISS, *Secretary*.

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#### VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the County Clinic Building on Tuesday, February 14, Doctor Strong presiding.

Members present were: Doctors Gronhøvd, Coffey, Bardill, Welch, Sterling Clark, Armitstead, Illick, Felberbaum, C. Smolt, Shore, Mosher, and Morrison. Guests were: Dr. Nelson of Fillmore and Mr. Hollingsworth of Ventura.

The scientific portion of the program was presented first. This consisted of an interesting illustrated lecture on *Head Injuries and Their Treatment* by Dr. Dorrell G. Dickerson of Los Angeles, followed by a good discussion.

A short business meeting followed.

Dr. Lois Wyatt's application for membership in the Society was approved.

The State Secretary's letter pertaining to methods of stimulating interest in meetings was read.

Dr. Grundy Coffey reviewed the bills introduced during the present session of the legislature.

It was decided to devote the March meeting to a discussion of medical legislation and economics.

A. A. MORRISON, *Secretary*.

## CHANGES IN MEMBERSHIP

### New Members (67)

*Contra Costa County*.—Walter Taylor.

*Los Angeles County*.—

Kenneth C. Brandenburg	William J. Matousek
Herman C. Bumpus	A. M. McCarthy
William W. Burbank	Meyer Paretzky
Paul Revere Burroughs	Charles R. Parrish
Vera R. Clough	Harry Poston
George R. Diven	Edward K. Prigge
Burns R. Eastman	Louis J. Regan
Ralph A. Ferguson	Benjamin H. Sher
Charles V. Ganoe	Isidor Singerman
William M. Heidenreich	Leonard W. Skelton
Herman S. Hendrickson	C. Richard Smith
E. Ross Jenney	C. E. Stafford
W. T. Johnson	Ellis Stephens
Albert W. Lindberg	Victor E. Thomas
Mary A. Manny	C. C. Vardon.
Ben D. Massey	

*Marin County*.—Bernard M. Conroy, Alex Miller.

*Orange County*.—Willard C. DuBois.

*Sacramento County*.—Paul H. Guttman, Norris Jones, Clarence W. Kilcher.

*San Bernardino County*.—Charles N. Abbott, Walter A. Andrews, H. O. Beeson, H. Milford Nelson, Philip Savage, Jr., Edward A. Sommer.

*San Diego County*.—John Thorpe Wells.

*San Francisco County*.—Fred D. Fellows, Charles C. Fulmer, Paul A. Gliebe, Genevieve F. Gaffney, Lewis G. Jacobs, George W. Kulchar, Pearl M. Smith.

*San Mateo County*.—A. H. Shaghoian.

*Santa Barbara County*.—Gilbert V. Hamilton, C. S. Stone.

*Santa Clara County*.—Charles H. Breuer, Frederic Wallace Borden, Percy Perry Poliak, Harvey M. Slater.

*Sonoma County*.—James G. Anderson, Clement A. Stimson.

*Tulare County*.—R. E. Cronemiller.

*Ventura County*.—Gilbert O. Gronhovd, Robert Maxwell Jones.

*Yuba-Sutter County*.—Neal M. Loomis, Stanley R. Parkinson, Leon M. Swift.

### Transferred (7)

Joseph B. Blackshaw, from Alameda County to Sonoma County.

Zach Coblentz, from Santa Barbara County to San Francisco County.

Clement E. Counter, from Orange County to San Bernardino County.

Bertrand S. Frohman, from San Francisco County to Los Angeles County.

Kathryn M. Kent, from Alameda County to Santa Clara County.

Orta E. Kuhn, from Alameda County to Napa County.

Alfred M. Tunnell, from Riverside County to Marin County.

### Resigned (11)

Thomas Addis, from San Francisco County.

Wilbur Bailey, from San Francisco County.

F. L. A. Gonzales, from San Francisco County.

Charles F. Griffin, from San Francisco County.

W. H. Kellogg, from Alameda County.

W. H. Kelly, from Alameda County.

F. B. Mandeville, from Alameda County.

John L. Pasmore, from Alameda County.

W. Bruce Sargent, from San Francisco County.

Hester M. Sutherland, from Alameda County.

Lloyd E. Wilson, from San Francisco County.

## In Memoriam

**Adler, Howard Felix.** Died at San Francisco, January 24, 1935, age 51. Graduate of Harvard University Medical School, Boston, 1908, and licensed in California the same year. Doctor Adler was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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**Campbell, Victor Emmanuel.** Died at Fresno, November 28, 1934, age 32. Graduate of the University of Colorado School of Medicine, Denver, 1930, and licensed in California the same year. Doctor Campbell was a member of the Fresno County Medical Society, the California Medical Association, and the American Medical Association.

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**Eytinge, Ernest Joseph.** Died at Redlands, January 20, 1935, age 54. Graduate of the Columbia University College of Physicians and Surgeons, New York, 1904. Licensed in California in 1919. Doctor Eytinge was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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**MacGowan, D. Granville.** Died at Los Angeles, January 31, 1935, age 78. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1879. Licensed in California in 1886. Doctor MacGowan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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**Tucker, Heber Olney.** Died at Santa Barbara, December 19, 1934, age 38. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1929, and licensed in California the same year. Doctor Tucker was a member of the Santa Barbara County Medical Society, the California Medical Association, and the American Medical Association.

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**Weger, George Stephen.** Died at Redlands, January 16, 1935, age 60. Graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1898. Licensed in California in 1923. Doctor Weger was a member of the San Bernardino County Medical Society, the California Medical Association, and the American Medical Association.

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**Weymann, Morie Frederick.** Died at Los Angeles, January 13, 1935, age 35. Graduate of Washington School of Medicine, St. Louis, 1922. Licensed in Cali-

fornia in 1923. Doctor Weymann was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Zussman, Samuel.** Died at San Francisco, February 3, 1935, age 72. Graduate of the University of Strassburg, Germany, 1888. Licensed in California in 1891. Doctor Zussman was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

#### OBITUARIES



**Davis Granville MacGowan**  
1857-1935

WHEREAS, Our beloved fellow member and colleague, Davis Granville MacGowan, has been called from his earthly labors; and

WHEREAS, During his half century of professional service, Doctor Granville MacGowan was identified with nearly all efforts having to do with the advancement of scientific and organized medicine; and

WHEREAS, As president and in other official capacities in the Los Angeles County and California Medical Associations, the Los Angeles County Hospital, the California Hospital, the School of Medicine of the University of Southern California, and other organizations and institutions, he carried out his responsibilities with great credit to himself, to the profession he loved, and to his fellow citizens; now therefore be it

*Resolved*, By the Board of Councilors of the Los Angeles County Medical Association that the sympathy of the members of this Association be extended to the bereaved family; and be it further

*Resolved*, That a copy of these resolutions be spread upon the minutes, that they be printed in the bulletin of the association, in the official journal of the California Medical Association, and a copy be sent to the family.

ROBERT V. DAY  
GEORGE H. KRESS  
WILLIAM DUFFIELD  
JOSEPH M. KING  
WILBUR B. PARKER  
J. J. O'BRIEN

#### BIOGRAPHICAL SKETCH OF DAVIS GRANVILLE MAC GOWAN

Davis Granville MacGowan was born at Davenport, Iowa, April 12, 1857, of Colonial stock, his paternal ancestors coming to Georgia from Scotland with

Oglethorpe. He attended the Millersville Normal School. He was a student at the University of Pennsylvania, receiving the M. D. degree in 1879. He took up postgraduate work at Berlin in 1880, in Vienna in 1882, and in Paris in 1883. Doctor MacGowan was an interne at the Blockley Hospital, Philadelphia in 1879; at the Charity Hospital of Berlin in 1880. Doctor MacGowan came to California in 1886, doing general practice from 1885 to 1890. His specialty since that time was genito-urinary surgery. During 1889 and 1892 he was the health officer of the City of Los Angeles. He held the chair of professor of dermatology and of genito-urinary diseases at the College of Medicine, University of Southern California from 1887 to 1909. For more than twenty-five years he was an attending genito-urinary surgeon at the Los Angeles County Hospital. He was an ex-president of the following medical associations: Los Angeles County Medical Association, Southern California Medical Society, and California Medical Association. He was a member of the American Urological Association, and Association Internationale d'Urologie.



**Ernest J. Eytinge**  
1880-1935

Dr. Ernest J. Eytinge of Redlands died in a few hours after injury in an automobile accident in Las Vegas, Nevada, on January 20, 1935.

Doctor Eytinge was born in New York City. He was graduated from the Columbia College of Physicians and Surgeons in 1904, and entered the United States Navy as surgeon on completion of his internship. He served his country with honor and distinction for a period of fourteen years, after which he was retired with the rank of Lieutenant-Commander.

During his service he was stationed at Guam, where he became much interested in the treatment of leprosy; in Shanghai, where he undertook active operative work in the local hospital, and in various other foreign assignments.

On sick leave at the time of the entrance of the United States into the World War, Doctor Eytinge returned at once to active duty and did splendid service in the hospital at Mare Island and on convoy duty with the transports across the Atlantic.

On permanent retirement from the Navy at the conclusion of the war, he located in Redlands and practiced there from 1919 till his death.

Inspired by the highest ideals of the medical profession, an ardent patriot, a loving husband and devoted father, and with a keen sense of his civic and professional duties, the untimely passing of this brilliant surgeon brought great sorrow to all who knew him.

C. G. HILLIARD.

## THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION\*

MRS. PHILIP SCHUYLER DOANE ..... President  
MRS. ELMER BELT ..... Editor and Chairman of Publicity

### State Auxiliary News

**Auxiliary Convention Plans.**—Our state president announces that the Auxiliary's plans for this year's convention in Yosemite, May 13 to 16, will be completed at the state board meeting on February 15 at Oakland. They will be printed in our pages here in the April issue. If you have not already sent for your reservations—news from the convention chairman, Mrs. Frederick N. Scatena of Sacramento, says they are fast being taken up—we hope you will soon do so and not miss this great gathering of the medical clans from every corner of our State.

Mrs. Doane sent a special invitation to the Auxiliary's national president, Mrs. Robert W. Tomlinson of Wilmington, Delaware, to be her personal guest at the 1935 California convention. It was with real regret that Mrs. Tomlinson wrote that she could not be with us. The press of responsibilities for the June conventions of the Auxiliary and of the American Medical Association meeting simultaneously in Atlantic City prevent her from taking time in May for the long journey from coast to coast.

**New County Presidents.**—December elections in some of the county organizations have brought changes in their officers and directors for the coming months. The following list of presidents for the twelve organized counties include the new presiding officers and are correct to May, 1935. State Auxiliary officers and the county presidents are listed each month on page 6 of the advertising section of CALIFORNIA AND WESTERN MEDICINE, and are given here simply to call your attention to the changes just made:

Alameda—Mrs. Robert T. Sutherland, Oakland.  
Contra Costa—Mrs. M. L. Fernandez, Pinole.  
Kern—Mrs. N. N. Brown, Bakersfield.  
Los Angeles—Mrs. John V. Barrow, Los Angeles.  
Mendocino—Mrs. Homer H. Wolfe, Fort Bragg.  
Orange—Mrs. Harry G. Huffman, Santa Ana.  
Riverside—Mrs. Hervey S. Faris, Riverside.  
Sacramento—Mrs. Frederick N. Scatena, Sacramento.  
San Diego—Mrs. Emil C. Black, San Diego.  
San Joaquin—Mrs. George H. Sanderson, Stockton.  
Santa Barbara—Mrs. John Van Paing, Santa Barbara.  
Santa Clara—Mrs. C. Kelly Canelo, San Jose.

**News Notes from National.**—Wilson County, Kansas, which is well organized medically, has an Auxiliary which has attained that ideal of membership for which we all strive—a 100 per cent quota of all the eligibles. Many of us thought it could never be done, but there it is. It can be done in Kansas.

In 1930 the Fulton County Medical Society of Georgia discussed the possibility of some day acquiring

a new building, and the Auxiliary there straightway started an investment fund to run not less than five years and to be used in furnishing a room for the Auxiliary when the good day came. The doctors have just bought the ground for their building, and the Auxiliary fund, quite separate from their regular accounts, has reached the tidy sum of \$853.

The Racine County Medical Auxiliary in Wisconsin has been making a study of the various county and city institutions, and to date has visited several types of hospitals, including the Isolation Hospital, County Farm and Asylum, the County Sanitarium, the Southern Wisconsin Colony of Feeble-minded and Epileptics, as well as going to the City Filtration Plant.

The Woman's Auxiliary to the Oregon State Medical Society took an intensive interest and an active part in the fight against a proposed amendment to the state constitution which would have nullified the Basic Science Law passed by the 1933 legislature. For eight months before the election the Auxiliary took this measure and made it an educational issue, building their entire program around it and sending out information on the questions involved. The Oregon Auxiliary deserves no small praise for their part in the campaign which ended in a defeat by more than 115,000 majority of this amendment which could only be construed as a step backward.

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### County Auxiliary Reports

**Alameda County.**—The January meeting of the Woman's Auxiliary to the Alameda County Medical Association was held on the 18th at the Women's Athletic Club in Oakland. Hostesses for the lunch were Mrs. Clarence B. Hills, assisted by Mrs. Leonard Barnard and her committee. Besides the regular business session there were songs by Miss Evelyn Fiegenberg and an address by Dr. B. W. Black, Medical Director of County Institutions, upon his field of work. The latter part of the afternoon was given over to cards for those who enjoyed playing.

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**Contra Costa County.**—The Contra Costa County Auxiliary had an interesting meeting at the Mount Diablo Country Club. It was held in the central part of the county, to be easily accessible to all the doctors' wives, the object being a membership drive and a welcome home for our president, Mrs. M. L. Fernandez, returning home from a four months' African cruise. She gave a very interesting and vivid description of a trip from Johannesburg to Victoria Falls, telling of the different tribes, the mode of travel, the scenery, and the animal life. It was greatly enjoyed by everyone present.

Mrs. Thomas J. Clark, president-elect of the State Auxiliary, spoke on *Reasons for an Auxiliary*. Mrs. T. Hanna of the County Federated Women's Clubs spoke on their project, *Medium-Priced Hospitalization for the Great Middle Class*. In compliance with a letter from the State Auxiliary to hold the annual election of officers in May of this year, it was decided to hold over the present officers until that time. There were seven prospective members present and a delegation from the Alameda County Auxiliary, which included Mesdames Thomas J. Clark, Robert T. Sutherland, A. A. Alexander, Louis Dyke, and Harold Trimble. The meeting of our neighbors and the non-member doctors' wives of the county with our Auxiliary members will mean a closer bond of friendship and a larger Auxiliary.

Mrs. S. N. Weil, Secretary.

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**Los Angeles County.**—As a delightful departure from the usual custom of meeting at a central point in Los Angeles, the Glendale section entertained the Woman's Auxiliary of the County Medical Association at the Oakmont Country Club on January 22,

\*As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

Mrs. W. O. Leach acting as chairman in charge, with Mrs. Harry V. Brown as program chairman and Mrs. John B. Barrow, president, presiding. Following the luncheon, attended by about two hundred, the guests were entertained by Miss Mary Hobson, contralto, who sang a group of songs accompanied by Mr. W. E. Strowbridge, and by Mrs. Norman Whytock, who gave readings from the poems of Milne and of Edna St. Vincent Millay. The meeting then moved into the lounge, and Dr. Orrie Ghrist, recently returned from the South Seas, gave a talk illustrated with moving pictures, describing his trip, which exceeded in interest and ability the powers of the "Globetrotter," himself. Doctor Ghrist gave a comprehensive description of these islands as to position, geological formation, animal life, ethnology, architecture, and native dances. He explained the high increase in the incidence of tuberculosis among the natives by the influence of the missionary who insisted on the islanders wearing garments, which in rainy weather constituted a wet swathe on bodies unused to covering. The technique of making tapa cloth was also interestingly described. Altogether it was one of the most delightful talks we have heard, and it is the wish of the Auxiliary that Dr. and Mrs. Ghrist will take another trip and bring their experiences to us again.

As a result of interest on the part of about twenty-five Auxiliary members, Mrs. Charles E. Futch, with the assistance of Mrs. James F. Percy, has organized a class for the study of parliamentary procedure. The class is conducted by Elizabeth G. McKelvey, author of the "Ritual of Parliamentary Law for Ordinary Assemblies," and will consist of ten sessions of one hour each devoted to study and practice. The first meeting was held the hour preceding the luncheon at Glendale, and will be held regularly just before the main meeting of each month.

The Pasadena members of the county held a membership tea on January 29 at the home of Mrs. Rollan W. Kraft on Midlothian Drive in Altadena. Mrs. Harry Markoff, Mrs. George Dock and others of the Pasadena group assisted. Mrs. Philip Schuyler Doane, the state president, presided and presented Mrs. John V. Barrow, county president, who gave a short talk on the purposes and activities of the Auxiliary. Mr. Charles Arthur, Pasadena City Bacteriologist, spoke on the history of immunization, and was followed by Dr. Wilton L. Halverson, Pasadena City Health Officer, who gave a concise and vivid talk illustrated by slides depicting graphs of the decreasing incidence and mortality rate of diphtheria. Pasadena upholds its reputation as a model city in regard to one use to which its birth certificates are put. A year after a recorded birth a letter is sent to the parents by the Health Department suggesting immunization against diphtheria for the child, to be done either by the family physician or pediatrician in charge. Three or four pertinent facts on immunization are given in the letter by way of information.

Music by a string trio and delicious refreshments added to the pleasantness of the afternoon.

MRS. HAROLD E. CROWE,  
*Corresponding Secretary.*

*Orange County.*—At the February meeting on Tuesday the 5th, the Orange County Medical Auxiliary assembled at the home of Mrs. G. E. Raitt on North Ross Street in Santa Ana and heard an address by Dr. K. H. Sutherland on *Immunization*. He contrasted present-day conditions with those preceding the discovery of the smallpox vaccine in the eighteenth century and explained immunization for diphtheria, scarlet fever, whooping-cough, and typhoid. A short business session was in charge of the county president, Mrs. Harry Huffman. Refreshments were served from a lace-covered table brightened with yellow and orange appointments, at which Mrs. Hiram Curry

and Mrs. K. H. Sutherland poured. Co-hostesses with Mrs. Raitt were Mesdames D. R. Ball, M. W. Hollingsworth, and John McAuley.

ELIZABETH M. SUTHERLAND, *Secretary.*

*Sacramento County.*—The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. W. R. Briggs on Tuesday evening, January 15, with the president, Mrs. J. Howard Hall, presiding. The first business was the election of officers for the ensuing year. Mrs. C. B. Jones, who had been nominated as a director, stated that she found it impossible to serve this year, so Mrs. E. O. Brown was nominated from the floor to serve in her stead. With this exception the ticket as published last month was voted upon, and unanimously carried. The treasurer, Mrs. T. Binkley, reported seventy-seven paid-up members on January 1, 1935. Mrs. Hall then turned the meeting over to the new president, Mrs. Frederick N. Scatena. A rising vote of thanks was given Mrs. J. Howard Hall for the splendid year just passed under her leadership.

The two speakers of the evening, Dr. E. T. Rulison and Dr. C. B. McKee, were introduced. They proceeded to show lantern slides, illustrating their recent trip to European clinics, and to speak of the chief points of interest in their trip. The program gave the members much pleasure. At the conclusion of the address Mrs. Briggs, assisted by Mesdames A. M. Henderson, C. B. Jones, D. Schuyler Pulford, E. C. Turner, and Frank Krull, served delicious refreshments from a beautifully decorated tea table. The next meeting will be held at the home of Mrs. William K. Lindsay.

SARAH L. BRENDEN, *Secretary.*

*Santa Barbara County.*—The Auxiliary to the Santa Barbara County Medical Society met on Friday, January 4, at the home of Mrs. Horace F. Pierce. Thirteen members were present. A discussion of the advantages to be gained by changing the time of the election of officers to correspond with that of the State Auxiliary was introduced, and it was decided to change the by-laws so that the annual election would be held in May. It was also decided to fix the date for the regular meeting on the first Monday of each month.

Dr. R. C. Main of the Santa Barbara County Health Department and Dr. W. H. Eaton of the Santa Barbara City Health Department presented their views on the proposed county-wide health plan and gave a detailed and comprehensive survey of the present workings of their respective departments. Doctor Eaton maintained there is no remediable overlapping in the present three-unit system, holding that distances are too great for a satisfactory consolidation in the county. He believes that each community or unit to be better prepared to gauge its budget needs and to know its particular problems than would a board of supervisors, even though they were chosen to represent their own community. Doctor Main believes there is costly overlapping of facilities and in duties of officials and in duplication of records. The County Health Department at present has three headquarters—Santa Maria, Lompoc, and Santa Barbara—besides a separate set-up for the city of Santa Barbara and for its schools. Doctor Main stated that the one-unit county-wide health plan has been worked out at the request of the Santa Barbara City Council. This plan provides for the addition of experts in the field of public health and that, compared with the present three-unit plan, it would reduce the costs to Santa Barbara by \$18,860.

Tea was served at the conclusion of these interesting talks, with Mrs. A. Q. Spaulding and Mrs. W. R. Hunt assisting Mrs. Pierce with the pouring.

MRS. W. REMFRY HUNT, *Secretary.*

## NEVADA STATE MEDICAL ASSOCIATION

HORACE J. BROWN, M.D. Associate Editor for Nevada

E. E. HAMER, Carson City ..... President  
R. O. SCHOFIELD, Boulder City ..... President-Elect  
C. E. SECOR, Elko ..... First Vice-President  
HARRY W. SAWYER, Fallon ..... Second Vice-President  
HORACE J. BROWN, Reno ..... Secretary-Treasurer

### COMPONENT COUNTY MEDICAL SOCIETIES

#### WASHOE COUNTY

The Washoe County Medical Society had its regular monthly meeting Tuesday evening, February 12, at the State Building. After hearing the minutes read, the president asked if the Medico-Legal Committee was ready to report. In the absence of Doctor Brown, chairman, Doctor DaCosta made a tentative report and was instructed by the president that as soon as he was able to complete a report a called meeting of the Society would be held to act upon the report. There being no further business to be discussed, the president called upon the guest speaker of the evening, Dr. William G. Patton, former superintendent of the St. Louis County Hospital. Doctor Patton's address was on the epidemic of encephalitis, which occurred in St. Louis in the summer of 1933. The following is a résumé:

"The first patient that appeared at the St. Louis County Hospital was a negro, who was admitted on July 23, 1933, and tentatively diagnosed as tubercular meningitis. During the course of his illness a white woman was admitted with precisely the same symptoms and the additional history that her husband had been recently discharged from a sanitarium, where he had been treated for tuberculosis. The first patient showed marked rigidity of his neck and pathologic toe signs were present; positive Kernig's. He also had evidence of pulmonary tuberculosis in his left chest which was quite marked and extensive. There was evidence of myocarditis with valvular lesion. Lumbar puncture was done and fluid was under increased pressure, cell count was 180, 70 per cent of which were lymphocytes. With the above history, diagnosis of tubercular meningitis was made. However, tuberculosis bacillus was not found in the spinal cord fluid. The day before the first patient died, a third patient, a woman, was admitted with precisely the same picture and a diagnosis made of encephalitis. We then realized we were in the midst of an epidemic of encephalitis, and during the next two days ten to twelve additional cases were admitted. The first patient admitted was the only case that showed lethargic symptoms. All other cases appeared as typical meningitis symptoms, showing marked irritability and maniacal symptoms and frequently had to be restrained.

"Chief complaint: Severe headache for several days previous, increasing in severity, with no relief from all sorts of treatment. Coincident with headache, increase of temperature from 101 to 108 degrees. Generalized aches and pains throughout the whole body. Occasional nausea and vomiting. Slight to marked rigidity of neck. One or two cases showed double vision. Occasionally a lethargic condition appeared.

"As cases progressed they became delirious, irrational and unconscious, occasionally showing loss of sphincter control with incontinence.

"Examination revealed: Tremor of tongue, very dry. Tremor of hands and arms. Pupils equal and reacted to light actively. Pulse, 80 to 100; respiration, 18 to 30; pronounced neck rigidity; positive Kernig sign. Catatonic symptoms appeared occasionally. Absence of abdominal reflex. Superficial reflexes, active or hyperactive. Hypersensitive to touch and pressure

to parts of body, especially the extremities. Positive Babinski, positive Chaddock, positive Gordon, positive Oppenheim.

"Spinal fluid showed: Increased pressure. Clear and colorless. Globulin positive. Sugar increased. Cell count ranged from 1,200 to 1,400. Negative to cultures.

"Blood findings: Twelve thousand to twenty-five thousand leukocytes. Schilling test showed, J. 8 and stabs and bands 23; segments, 58. Lymphocytes, 11 or more.

"Blood picture: Highly infectious, with a pronounced shift to the left. Disease affected mostly the ages between forty and sixty. Few, if any, children suffered from the disease. Only in one or two instances other persons in families contracted the disease. Patients usually died within ten days or recovered. The maniacal type predominated and few lethargic types were seen. After one year, with periodic examinations every three months, no after-effects showed from the disease. Filterable virus apparent cause of disease. Mosquitos, after experimentation, proved not to be the contributory cause or carrier. Disease not related to vesicular stomatitis, equine-encephalomyelitis, acute poliomyelitis, or Japanese encephalitis. Disease did resemble the Australian epidemic. Reports indicate successful transmission of a virus, isolated from cases of encephalitis of the St. Louis epidemic, to monkeys and mice. Swiss mice are more susceptible and cheaper. More fatal to persons suffering from degenerative diseases. Horse and man, different strains.

"Pathology: Marked edema of the brain. Capillary hemorrhages seen throughout cortex of brain, kidney and spleen.

"Treatment: Repeated puncture of the spinal column to aid severe headache, otherwise treatment symptomatic. Adrenalin given in five-drop doses, subcutaneous every four hours, in a number of cases performed almost a miracle and the patient recovered. Adrenalin, however, should be stopped when the patient shows marked restlessness and irritability.

"Patients were discharged from the hospital at the end of ten days or two weeks, when symptoms had subsided.

"In the beginning, all cases were isolated, but later, due to the great number developing the disease, they were placed in wards in the General Hospital, without any material effect on persons coming in contact with them. Few, if any, doctors or nurses became infected while administering to the infected patients.

"In the city of St. Louis, 507 cases were reported with 132 deaths; St. Louis County reported 537 cases and 92 deaths; outstate, 1 case with 1 death. All cases were isolated as soon as reported to health authorities.

"The Metropolitan Health Council was composed of the Health Commissioner of St. Louis, health commissioners of various municipalities of St. Louis County, the superintendent of the Isolation Hospital of St. Louis, the superintendent of St. Louis County Hospital, and the Hospital Commissioner of St. Louis. Other physicians and public health workers were also invited.

"The purpose of the Council was: (a) To coördinate all public health activities in the metropolitan area for the handling of emergency; (b) to adopt uniform rules and regulations as far as possible for handling cases of contagious and infectious diseases; (c) to adopt uniform rules and regulations for isolation and quarantine.

"A central laboratory was established where all blood and spinal fluids were sent for examination. Pathologists connected with the central laboratory were notified when post-mortems were being performed at the various hospitals so they might attend all cases of encephalitis.

"No doubt the prompt diagnosis and isolation materially reduced the total number of cases and assisted in checking the epidemic."

THOMAS W. BATH, Secretary.

## MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

### NEWS

#### Coming Meetings

*American Medical Association*, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

*American Urological Association*, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

*California Medical Association, Yosemite National Park*, May 13-16, 1935. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

#### Medical Broadcasts\*

*American Medical Association Health Talks*.—The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, central standard time.

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4:00 to 4:15, central standard time.

*San Francisco County Medical Society*.—The radio broadcast program for the San Francisco County Medical Society for the month of March is as follows:

Tuesday, March 5—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: The Value of Animal Experimentation to Medical Science.  
Tuesday, March 12—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Reasons for Periodic Health Examination.  
Tuesday, March 19—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Overweight—A Liability.  
Tuesday, March 26—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: In Case of Accident.

*Los Angeles County Medical Association*.—The radio broadcast program for the Los Angeles County Medical Association for the month of March is as follows:

Saturday, March 2—KFI, 9 a. m. Subject: The New Frontier.  
Saturday, March 2—KFAC, 10 a. m. Subject: Your Doctor and You.  
Tuesday, March 5—KECA, 11:15 a. m. Subject: The New Frontier.  
Saturday, March 9—KFI, 9 a. m. Subject: The New Frontier.  
Saturday, March 9—KFAC, 10 a. m. Subject: Your Doctor and You.  
Tuesday, March 12—KECA, 11:15 a. m. Subject: The New Frontier.  
Saturday, March 16—KFI, 9 a. m. Subject: The New Frontier.  
Saturday, March 16—KFAC, 10 a. m. Subject: Your Doctor and You.  
Tuesday, March 19—KECA, 11:15 a. m. Subject: The New Frontier.  
Saturday, March 23—KFI, 9 a. m. Subject: The New Frontier.  
Saturday, March 23—KFAC, 10 a. m. Subject: Your Doctor and You.  
Tuesday, March 26—KECA, 11:15 a. m. Subject: The New Frontier.  
Saturday, March 30—KFI, 9 a. m. Subject: The New Frontier.  
Saturday, March 30—KFAC, 10 a. m. Subject: Your Doctor and You.

\* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

**Physicians' Income Tax for 1935.**—The American Medical Association Bureau of Legal Medicine and Legislation, on page 403 of the February 2 issue of *The Journal of the American Medical Association* prints its annual survey of the federal income tax requirements. The article discusses the income tax in relation to physicians, and is an excellent summary of the subject.

**California Tuberculosis Association.**—The 1935 annual meeting of the California Tuberculosis Association will be held in Long Beach, March 26 to 30. An extensive program has been arranged, the scientific papers being presented through clinical and sociological sections of the association. A large number of physicians and social welfare workers who are interested in tuberculosis work are included among the speakers.

All who are interested in copies of the detailed program may obtain further information by writing to the chairman of the Program Committee, Dr. Philip H. Pierson, or to the executive secretary of the association, Mr. William F. Higby, 45 Second Street, San Francisco.

**Seventh International Congress on Industrial Accidents and Diseases.**—The Seventh International Congress on Industrial Accidents and Diseases will be held at Brussels, Belgium, from July 22 to 27, 1935. The American Committee of the Congress is under the chairmanship of Dr. Fred H. Albee of New York for the Section on Accidents, and that of Dr. Emery R. Hayhurst of Columbus, Ohio, for Industrial Diseases.

The American delegation to the congress will sail from New York on August 8 and visit London, Amsterdam, The Hague and Paris and, optionally, Budapest. Physicians interested in the congress or in the medical tour in conjunction with it may address the secretary, Dr. Richard Kovacs, 1100 Park Avenue, New York.

**American Urological Association.**—On Tuesday, Wednesday and Thursday, June 24 to 29, 1935, from 9 a. m. to 5 p. m., scientific sessions of the American Urological Association will be held in the Gold Ballroom of the Palace Hotel, San Francisco. On Wednesday the Ramon Guiteras lecture will be delivered by Dr. Hugh H. Young, professor of urology, Johns Hopkins University. On Friday the sessions of the Western Branch Society, American Urological Association will be held. On Saturday the Association will be the guests of the Oakland urologists. There will be operative and dry clinics at the Highland Hospital. In the afternoon there will be a boat ride on the Bay for the purpose of inspecting the sites of the bridges. From the standpoint of entertainment, on Monday, June 24, a golf tournament to be held at Lakeside Golf Club. Monday night, June 24, will feature a stag banquet at the Lakeside Golf Clubhouse. On Wednesday night the banquet of the American Urological Association will take place, and on Thursday night there will be a dinner dance. Both of these events will be held at the Palace Hotel.

All urologists who are members of the California Medical Association and who are interested, are invited to attend the scientific sessions as guests. Further information may be had by writing to Dr. Miley B. Wesson, San Francisco.

**The American Society of Tropical Medicine.**—At the thirtieth annual meeting of the American Society of Tropical Medicine, held in San Antonio, Texas, in November, 1934, the following officers were elected: President, Edward B. Vedder of Washington, D. C.; president-elect, Henry E. Meleney of Nashville, Tenn.; vice-president, Lewis W. Hackett of New York, N. Y.; editor, Charles F. Craig of New Orleans, La.; secretary-treasurer, Alfred C. Reed of San Francisco. This brings the secretaryship of the society to the University of California and is a recognition of the importance of tropical medicine, centering in the University of California and the Pacific Coast.

**Press Report of American Medical Association Special Session of House of Delegates.**—In one of the other departments of this issue the report of the American Medical Association House of Delegates is printed in full (see page 207). The "Associated Press" sent out the following report to the newspapers on its circuit:

**Forced Sickness Insurance Opposed at Assembly of National Association.**—The American Medical Association recently reiterated its vigorous opposition to compulsory sickness-insurance plans being studied by the President's Committee on Economic Security.

But it tempered its stand by approving projects for setting up a system of voluntary illness insurance on a community basis.

Decrying what it termed attempts to regiment the profession in proposed legislation and attacking certain sections of the Wagner Bill embodying the National Administration's social security program, the Association's House of Delegates adopted a declaration of policy for its one hundred thousand member physicians.

The report, carried unanimously at the second extraordinary session in the organization's history, set forth:

"The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal Government, the governments of the individual states or by any individual, industry, community or similar body."

**A Motion-Picture Film for Mothers.**—In order to educate mothers who are about to assume the responsibility of the care of the newborn, a film has been produced. The care and feeding of infants as it should be done in the average home, as well as advice for the mother's own health, is shown in detail.

The film was produced by the department of obstetrics and gynecology of the University of Southern California at Los Angeles, under the personal direction of Doctors Lyle G. McNeile and Donald G. Tollefson, in cooperation with the producers of Carnation Milk.

It is a 35-millimeter film in three reels, requiring about thirty-five minutes to show, and was made to replace or amplify the present nurses' demonstration as given in hospitals for mothers who are about to leave the hospital. The film was shown at the Hall of Science at the Century of Progress in Chicago during the closing week of the Fair, and was enthusiastically approved by all who viewed it.

The film may be loaned without charge for an indefinite time to any ethical hospital in which, at least, fifty confinements occur each month. The film must be shown at least twice a week and a report of the number of showings, as well as the number of persons who viewed the film, must be forwarded once a month.

At the California Hospital at Los Angeles the film is shown three times a week in the Solarium of the obstetrical floor for the mothers. It was also found advisable to show the film once a week in the evenings for the relatives of the maternity patients as well as the practical nurses who are to assist in the care after returning from the hospital.

Further information may be obtained by writing to Dr. Donald G. Tollefson, 511 South Bonnie Brae Street, Los Angeles.

**Membership Certificates.**—Have you framed yours for display in your office? If not, do so today and so give publicity to your county society. Patients are often recommended to only consult society members.

**Postgraduate Course on Neuropsychiatry at the Menninger Clinic, Topeka.**—A postgraduate clinic in neuropsychiatry in general practice will be held at the Menninger Clinic, Topeka, April 15 to 20, inclusive. Lectures, case studies, and seminars included in the five and a half-day course will be exclusively directed to the application of modern neuropsychiatric principles to the cases which the general practitioner frequently sees in this field.

The course will be given by the members of the staff of the Menninger Clinic, with the assistance of Doctors W. McK. Craig and Henry Woltman of the Mayo Clinic, and Dr. Titus H. Harris of the University of Texas Medical School.

**Los Angeles County Hospital Clinical Conferences.** On March 28 and 29 an important clinical session will be held in Los Angeles, under the auspices of the Clinical and Statistical Section of the Los Angeles County Medical Association.

Clinics will be held at the Los Angeles County Hospital.

The Clinical and Statistical Section of the Los Angeles County Medical Association, realizing the desire of the general profession for postgraduate clinics, has made it possible to utilize the material available at the Los Angeles General Hospital. The attendance and interest shown by the general profession will be the deciding factor as to the establishment of clinics held at regular intervals in the future, thus making the clinical material at the County Hospital available to the profession at large.

Clinical lectures will be given constantly during two days in the two auditoriums of the County Hospital by various members of the staff. Each subject will be complete in itself. There will be no general discussions, but opportunity will be afforded those who are particularly interested in the topics discussed to visit the wards or departments of the hospital and see demonstrations of patients. Here questions may be asked and discussions entered into with members of the staff.

All members of the California Medical Association and visiting members of other state associations are most cordially invited to attend these clinics and demonstrations.

There are no registration or other fees required.

The details of the various papers and clinics on the program follow:

#### CLINICS AT LOS ANGELES COUNTY HOSPITAL

##### Thursday, March 28

###### AUDITORIUM

###### Obstetrics

Lyle McNelle, Chairman

9:00 to 10:30 a. m.

Complications of Pregnancy: Diabetes, Cardiac, Hyperthyroid, Tuberculosis—D. G. Tollefson.  
Toxemias of Pregnancy—Lyle G. McNelle.  
Indications of Operative Interference—E. M. Lazard.  
After which, conferences in the wards.

###### NURSES CLASSROOM

###### Orthopedics

John C. Wilson, Chairman

9:00 to 10:30 a. m.

Fractures of the Hip—Alfred E. Gallant.  
Skeletal Traction—John Dunlop.  
Fractures of the Elbow—John C. Wilson.  
After which, conferences in the wards.

###### Urology

Robert V. Day, Chairman

9:00 to 9:40 a. m.

Ureteral Calculi—Harry M. Martin.

9:45 to 10:30 a. m.

Renal Tuberculosis—J. C. Negley.

## Urology Staff Room

- 10:30 to 11:10 a. m.  
Prostatic Obstructions—Robert V. Day.  
11:15 to 12:00  
Bladder Tumors—J. J. Crane.

## Surgery

Clarence G. Toland, Chairman

- 10:30 a. m. to 12:00  
Minor Surgery—Paul McMasters.  
Plastic Surgery—W. S. Kiskadden.  
Chest Surgery—H. E. Schiffbauer.  
Ward conferences.

## Contagious Diseases

Paul Hamilton, Chairman

- 10:30 a. m. to 12:00  
Scarlet Fever—O. Halverson.  
Pollomyelitis—A. G. Bowers.  
Technique of Handling Contagious Diseases—Robert Meals.  
Whooping Cough—M. Tobias.  
Ward conferences.  
Buffet lunch.

## Gynecology

Rafe C. Chaffin, Chairman

- 1:30 to 3:00 p. m.  
Cancer of Cervix—Wilburn Smith.  
Pelvic Relaxation—Henry Shaw.  
Pelvic Inflammations—Homer Seaver.  
Ward conferences.

## Cardiology

B. O. Raulston, Chairman

- 1:30 to 3:00 p. m.  
The Hypertensive Heart—Verne Mason.  
Acute Coronary Thrombosis—M. H. Leake.  
Cardiac Irregularities—Manning Clark.  
Chronic Rheumatic Endocarditis—Richard Ware.  
Ward conferences.

## Internal Medicine

F. M. Pottenger, Chairman

- 3:00 to 4:30 p. m.  
Hemoptysis—Carl Howson.  
Artificial Pneumothorax—E. W. Hayes.  
Acute Respiratory Infections—Roy E. Thomas.  
Abdominal Ascites—John C. Ruddock.  
Ward conferences.

## Allergy

- 3:00 to 4:30 p. m.  
Asthma; Hay Fever; Allergic Skin Manifestations—R. W. Lamson.  
Ward conferences.

## Cautery Surgery

Continuous demonstrations will be held throughout the day by James F. Percy and staff.

\* \* \*

Friday, March 29

AUDITORIUM

## Internal Medicine

John V. Barrow, Chairman

- 9:00 to 10:00 a. m.  
Pernicious Anemia—H. P. Hare.  
Cardiorenal Syndrome—Harry H. Wilson.  
Diabetes—Howard West.  
Ward conferences.

## NURSES CLASSROOM

Eye, Ear, Nose, and Throat

George H. Kress, Chairman

- 9:00 to 10:30 a. m.  
Hypertrophied Tonsils and Adenoids in Children—Acute Middle Ear—Frank Detling.  
Cancer of Larynx—Simon Jesberg.  
Syphilis and the Eye—M. M. Beigelman.  
Glaucoma—L. A. J. La Motte.  
Ward conferences.

## FOURTH FLOOR

## Urology

- 9:00 to 9:40 a. m.  
Renal Tuberculosis—A. A. Kutzmann.  
9:45 to 10:30 a. m.  
Ureteral Calculi—Transurethral Removed—W. B. Parker.  
Urology Staff Room  
10:30 to 11:10 a. m.  
Bladder Tumors—Paul A. Ferrier.  
11:12 a. m. to 12:00  
Prostatic Obstruction—H. C. Bumpus.

## General Surgery

Charles E. Phillips, Chairman

- 10:30 a. m. to 12:00  
Appendicitis—Charles Sturgeon.  
Intestinal Obstruction, with X-Ray Demonstrations—George Thompson, X-Ray Department.  
Ward conferences.

## Pediatrics

Oscar Reiss, Chairman

- 10:30 a. m. to 12:00  
Rheumatic Heart and Allied Conditions—Philip Rothman.  
Vitamin Deficiencies, Rickets, Scurvy—Earl Moody.  
Upper Respiratory Infections—Oscar Reiss.  
Ward conferences.  
Buffet lunch.

## Internal Medicine

Madison T. Keeney, Chairman

- 1:30 to 3:00 p. m.  
Common Skin Diseases—E. D. Lovejoy.  
Syphilis: Secondary Stage—Stanley Chambers.  
Wards: C. N. S. Lues; Samuel D. Ingham.  
Wards: Psychoses—Martin G. Carter and associates.

## Symposium

Roy A. Carter, Chairman

- 1:30 to 3:00 p. m.  
Gastro-Intestinal Lesions:  
X-Ray Department.  
Surgery Department.

## General Surgery

W. H. Kliger, Chairman

- 3:00 to 4:30 p. m.  
Hemorrhoids—Williams Daniels.  
Fissure—A. J. Murietta.  
Fistula in Ano—E. J. Clemons.  
Breast Tumor—C. J. Rowan.  
Head Injuries—Carl Rank, G. H. Patterson, L. J. Adelstein, R. B. Raney.

## Symposium on Uremia

Newton Evans, Chairman

- 3:00 to 4:30 p. m.  
Uremia—Medical Department, Harry H. Wilson; Obstetrical Staff; Urological Staff; Neurological Staff.  
Demonstration of pathological material.

\* \* \*

Buffet Supper and Entertainment, 6:30 p. m.

County Medical Building, 1925 Wilshire Boulevard  
With a "Road Show," under the direction of D. G. Tollefson.

## CORRESPONDENCE

Concerning collection agency standards—A communication from the California Association of Collection Agencies:

March 1, 1935.

To the Editor:—Although the California Association of Collection Agencies has truly made remarkable progress in sponsoring and fostering a high standard of business ethics, its officers are fully aware that only "bachelors' wives and old maids' children are always perfect." As Diogenes said, "To arrive at perfection, one should have sincere friends, or inveterate enemies; because he would be made sensible of his good or ill conduct either by the censures of one or the admonitions of the other."

In an endeavor to be of service to the medical fraternity, and in an ambition to correct and discipline those in our ranks who may carelessly, or otherwise, commit errors that are contrary to public welfare, we earnestly ask that our attitude be brought to the attention of physicians and that they, in turn, notify our Association of any untoward practices on the part of collection agents.

Our Association has just recently adopted a revised code. Among other important advancements, a rule is now in order making it incumbent for agents to furnish clients with monthly accountings whether they are insisted upon or not. This particular rule was initiated by the majority of our members to discourage contracts with buried clauses that often made for dissatisfaction on the subject of remittances. No Association member can now maintain his membership and violate this rule. Eventually, when the law is revised, no collection agency can be licensed unless it makes monthly accounting a practice.

As you are probably aware, the California Association of Collection Agencies sponsored the present laws wherein all collection agencies are now licensed by and bonded to the State, and are under direct supervision of the State Superintendent of Collection Agencies. In addition, if the medical fraternity will cooperate by reporting unethical or unsatisfactory actions on the part of collection agents, the Association will lend its assistance to the State authorities in effecting corrections.

Respectfully,

CALIFORNIA ASSOCIATION OF COLLECTION AGENCIES.

By Louis Spencer, President.

Income Securities Building, Oakland.

#### Concerning "Tuberculosis Subsidy" Assembly Bills 1927 and 1928:

To the Editor:—I enclose herewith a copy of a resolution presented to the Trudeau Society of Los Angeles at its regular meeting Tuesday February 26.

Very truly,

CARL R. HOWSON, M. D.

#### RESOLUTION

WHEREAS, For the past twenty years there have been paid to the counties (or cities) of the State of California from State funds a subsidy of \$3 per week for every indigent patient cared for in a tuberculosis ward or hospital by said counties; and

WHEREAS, There have been introduced into the California Legislature two bills, A. 1927 and A. 1928, which have for their purpose the removal of the present legal requirement that such tuberculosis wards or hospitals shall conform to the regulations of, and be approved by, the State Bureau of Tuberculosis before such State aid shall be forthcoming; and

WHEREAS, During the twenty years of its existence it has been conclusively demonstrated that the enforcement of this requirement has been the most important single factor in the improvement of the provision for and the treatment of these patients throughout the State, and the attainment of the present high standards for their care; and

WHEREAS, The removal of this restriction will not only increase the payments from the State treasury, but will also open the way for possible serious abuses; now therefore be it

*Resolved*, That the Trudeau Society of Los Angeles is of the opinion that the passage of these bills would inevitably tend to lower the quality of care given these unfortunate sick, and would render further improvements in their care in public institutions extremely difficult; and be it further

*Resolved*, That we request our representatives in the Assembly and Senate to vigorously oppose the passage of these bills.

#### Concerning article in February issue:

To the Editor:—Referring to the paper on "Pharyngo-Esophageal Diverticulum, Pulsion Type" by Doctor Ziegelman, on pages 85 to 90 of the February, 1935, issue, he quotes a letter by Lord Moynihan.

There is an error in the quotation of Moynihan's letter as published in *Surgery, Gynecology and Obstetrics*, page 128 of the January, 1932, issue, in reference to the Laimer-Haackermann area. To quote Lord Moynihan correctly would be as follows:

"It is Laimer, who was prosecutor at Graz, and Haackermann, now of Bremen, in whom interest centers. The 'point' to which Doctor McEvers refers is not a point, but an area. The 'Laimer-Haackermann point' becomes, therefore, the 'Laimer-Haackermann area.'"

It is true that these two names have been misspelled in the literature and also in the medical dictionaries. In *The American Illustrated Medical Dictionary* (Dorland), thirteenth edition, published in 1925, the names are given as "Lannier-Hackerman area."

To correct the spelling of these names, they become *Laimer and Haackermann*.

I am writing only to call attention to the incorrect spelling of the names of both *Laimer and Haackermann*.

A. E. McEVERS, M. D.

1830 Wilshire Boulevard, Los Angeles.

#### Concerning Pan-American Medical Association cruise to Rio Janeiro:

To the Editor:—Enclosed find a news item concerning the Pan-American Medical Association which I am asking you to publish in *CALIFORNIA AND WESTERN MEDICINE*. You must realize the importance of this great Pan-American movement. The officials of the parent organization as well as myself will appreciate your publishing this.

Very sincerely yours,

CHARLES P. MATHÉ, M. D.

"The Pan-American Medical Association, which embraces the leading physicians and surgeons of the Western Hemisphere, will meet in New York to board the steamship *Columbia* of the Panama Pacific Line. The 40,000-ton luxury liner, the largest ever to cruise to South America, is being redecorated, and could accommodate one thousand passengers in the atmosphere of a smart beach club."

The ship will sail from New York on July 18, returning to New York on August 28. The itinerary will be as follows: New York, Havana, Curacao, five days at Rio de Janeiro (where a scientific congress will be held), three days at Santos (for attending a scientific convention at Sao Paulo), returning via Trinidad, Santo Domingo, Kingston (Jamaica), Havana, and New York.

During the voyage scientific meetings in all branches of medicine will be conducted. This will give an excellent opportunity for physicians, while enjoying an ideal summer holiday, to meet with and hear lectures by the leaders of the profession in all sections of surgery and medicine.

The Brazilian Government has suggested August for the congress there, as this is the time of the year that the climate is most delightful. His Excellency, Dr. Getulio Vargas, President of the Republic of Brazil, has expressed his pleasure at the selection of Rio de Janeiro and Sao Paulo for the congress and the opportunity his country will have of being the host to the members of the Pan-American Medical Association.

Apart from deriving definite scientific advantages from the cruise, the medical men will establish social contacts of lasting value to Pan-American relations and visit Rio de Janeiro, known as the most beautiful of all cities, with its famous Oswaldo Cruz Institute of Tropical Medicine; Santos, with its bathing beaches at the height of the season; Sao Paulo, with its world-renowned University and Instituto Sero-Therapeutico for the study of reptiles and poisons.

An inaugural dinner officially announcing the plans will be given by the Pan-American Medical Association on March 1 on board the steamship *Columbia* in honor of His Excellency, Dr. Oswaldo Aranha, Brazilian Ambassador to the United States.

Previous congresses of this association have been held in Havana (1929), Panama City (1930), Mexico, D. F. (1931), Dallas (1933). Last year a "floating congress," similar to the coming congress, was held in which 560 physicians, their families and friends took a cruise, visiting Cuba, Colombia, Venezuela, Panama, and Puerto Rico. The scientific meeting at Maracay, Venezuela, and the hospitality of His Excellency, General Juan Vicente Gomez, President of the Republic of Venezuela, were important features of last year's congress.

Thomas Cook and Son will be general managers of the cruise. The prices will range from \$450 for the forty-day cruise.

For further information, write to Pan-American Medical Association, 745 Fifth Avenue, New York City."

## SERA IN LOS ANGELES COUNTY

### A Summary of the Program Being Put Into Effect for the Medical Care of the Unemployed by the L. A. C. R. A., Coöperating with the Los Angeles County Medical Association.

Provisions for the medical care of the unemployed in Los Angeles County have been made.

The importance of this movement, in which State and Federal funds shall pay for medical services to be rendered to a considerable portion of our citizenry, should be appreciated by every physician.

In Los Angeles County, the Los Angeles County Relief Administration (L. A. C. R. A.) coöperating with the County Medical Association, will administer this emergency program under the supervision of the SERA (State Emergency Relief Administration).

Louis Boonschaft, M. D., has been appointed medical director of this service, with offices at 741 South Flower Street.

On February 6, to help expedite the formation of a panel of physicians and surgeons, the Los Angeles

County Medical Association sent out a letter and a return post card to the physicians and surgeons of Los Angeles County. The letter stated briefly what the program was. The post card was included to allow the profession of Los Angeles County to register for membership on this panel.

Complete details have not as yet been worked out, but generally this medical care will be administered as follows:

All those individuals in Los Angeles County who are entitled to relief under the State Emergency Relief program will be entitled to medical care.

For convenience Los Angeles County is divided into some twenty-odd unemployment districts. Each of these districts, under the supervision of the L. A. C. R. A., will have a social service unit. Each of these units will be supplied with a panel of doctors in that district. When an unemployed resident of that district is found to be in need of medical care he will be given an authorization certificate which he will take to his family physician, if he has one, or to another physician whom he may choose from the panel in that district.

This first certificate authorizes the physician to make his examination and diagnosis and render immediate treatment, either at his office or at the patient's home, according to the nature of the case. On this certificate the physician will make his recommendations for further treatment if it is indicated; these recommendations to be approved by the Medical Advisory Committee of three doctors of medicine in that district, selected by the County Medical Association and approved by the L. A. C. R. A.

Each member of the panel will receive from the L. A. C. R. A. special prescription pads. All prescriptions will be written in triplicate, one to be retained by the doctor, and two to be given to the patient. The patient will have these prescriptions filled at one of the several drug stores in that district that have arranged with the L. A. C. R. A. for this prescription work.

Doctor Boonshaft is preparing the various forms necessary to carry out this program. When they are completed a complete set of forms, together with a letter, explanatory of the whole system, will be mailed to each physician who has signified his willingness to become a member of the panel.

The offices of the Los Angeles County Medical Association have been besieged with telephone and mail inquiries asking questions about details. Most of these questions will be answered when the forms to be used are mailed to members of the panel of the L. A. C. R. A.

At the present time funds are available for medical care, but not for hospitalization. It is anticipated that funds for hospitalization will be available shortly.

The fees allowed at present are \$1.25 for an office call and \$1.75 for a home call.

No physician will be compensated for his services unless the unemployed patient brings proper authorization, with the exception possibly of night emergency calls. On such calls the doctor will be paid for his services if the call has been made on one who is found to be entitled to this service.

Methods of providing special medical care at this writing have not been worked out. Panel members will be informed of such details as they are perfected.

\* \* \*

The letter which was sent to the members of the Los Angeles County Medical Association pursuant to the above, follows:

LOS ANGELES COUNTY MEDICAL ASSOCIATION  
Los Angeles

February 6, 1935.

#### IMPORTANT! L. A. C. R. A. PANEL

To All Duly Licensed and Practicing Physicians and Surgeons in Los Angeles County:

The Los Angeles County Medical Association has been charged with the responsibility of offering to all duly licensed and practicing physicians and surgeons in Los Angeles County the opportunity to become members of the panel being created for the medical care of the un-

employed and their families under jurisdiction of the State Emergency Relief Administration.

Cases deserving of such care will be sent to their family physician if they have one in their unemployment district. If they have no such family physician, a physician on the district panel may be selected. These cases will carry authorization from the L. A. C. R. A. for such medical service.

The fees allowed are \$1.25 for an office call, and \$1.75 for a home visit. More complete information on fees and detailed methods of procedure will be sent to those physicians and surgeons who wish to accept a place on this panel.

The attached post card should be filled out completely and mailed immediately by all those who wish to take part in this work.

E. VINCENT ASKEY, M. D.,  
Secretary.

## FEDERAL NARCOTIC FARM

The first United States Narcotic Farm, near Lexington, Kentucky, will open for the reception of admissions on or about May 1. It will accommodate a maximum of one thousand persons and is designed to accommodate males only. Its object and purposes are to rehabilitate, restore to health and train to be self-supporting and self-reliant those who are admitted thereto. The control, management and discipline are to be maintained for the safekeeping of the individual and the protection of the community. Experiments are to be carried on to determine the best methods of treatment and research in this field, and the results disseminated to the medical profession and the general public, to the end that states may make some provision for establishing a similar policy for helping to solve the problem of drug addiction. The function of the institution at Lexington, therefore, assumes the character of a treatment and research center, and of an educational and rehabilitation center with certain custodial features superimposed.

Heretofore, as far as public policies are concerned, drug addiction has been regarded solely as a penal and correctional problem without cognizance being taken of its medical, sociological or economic significance. The institution is to be administered by the United States Public Health Service. As a matter of convenience to Fellows of the American Medical Association, there is herewith printed the regulations governing admissions to that institution. . . .

\* \* \*

The above was the opening paragraph of an article which was printed on page 574 of the February 16, 1935, issue of *The Journal of the American Medical Association*. Editorial comment in the same issue (page 566) was as follows:

#### Narcotic Farms—A Public Policy

Elsewhere in this issue appear the regulations governing the admission of persons to the federal narcotic farms, the first of which is being established at Lexington, Kentucky. Addiction to habit-forming drugs is widespread throughout the United States. All classes and groups of the general population are affected by such addiction in one way or another. The geographic distribution of these people corresponds relatively to the geographic distribution and density of the population; occupation, age periods of life, nativity, sex, color, and marital or educational status are not exempting factors. Thus, addiction to narcotic drugs resembles an endemic disease, for it is through and on the people. Based on knowledge available, it is estimated that there are about one hundred thousand drug addicts in the United States.

Perhaps there is no condition in which man is placed that is fully comparable with that of opium addiction, in which food, shelter, raiment, and all those things "by which men live" are cheerfully abandoned for the drug of choice. Contact and association with others who are addicted to the use of such drugs stand out as the more prominent and frequent immediate causes of addiction. The removal of addicts from American

communities is, therefore, a step in the direction of preventing further addiction.

The authorization and establishment of facilities for the confinement and treatment of persons addicted to habit-forming drugs bears a direct relationship to policies respecting enforcement of antinarcotic laws and the protection of the American community. Problems in penal and correctional procedure, the uses of narcotic drugs in medical practice, research and the quest for more accurate and fundamental knowledge concerning the nature of drug addiction and related phenomena will be studied to better advantage under the conditions prevailing when the new government institutions begin to function. Moreover, these farms are a response to the instinctive demands ever present in the American people that the sick and afflicted shall be set in the way of strength and hope.

## PROPOSED PUBLIC HEALTH LEGISLATION\*

### A List of Bills Submitted to the California Legislature Now in Session, and Having Relationship to the Public Health

#### I SENATE BILLS

*Senate Bill 19*, by Slater (referred to Committee on Criminal Law and Procedure). Relating to procedure when defendant in a criminal case claims insanity as a defense.

*Senate Bill 21*, by Slater (referred to Committee on Public Health and Quarantine). An act to regulate the production and distribution of serums, vaccines, bacterial cultures and viruses, to provide for the licensing of persons manufacturing, preparing and distributing the same, and to provide penalties for violation.

*Senate Bill 77*, by Mixer (referred to Committee on Public Health and Quarantine). Relating to agreements between counties and deposits of funds in connection with establishment and maintenance of tuberculosis hospitals.

*Senate Bill 98*, by Slater (referred to Committee on Public Health and Quarantine). Providing for licensing of persons who perform diagnostic tests on material from persons suffering from infectious or contagious disease and providing penalties for violations.

*Senate Bill 111*, by Gordon (referred to Committee on Hospitals and Quarantine). Making an appropriation for major construction and equipment at Napa State Hospital.

*Senate Bill 154*, by Williams (referred to Committee on Public Health and Quarantine). Amending Medical Practice Act to require a bond of \$250 in cases of appeal from judgment of the Board in revoking, suspending or placing on probation of the holder of any certificate. The bond to secure payment of the cost of appeal in case such appeal be decided against the defendant.

Adding to "Unprofessional Conduct" the following:  
"The fraudulent representation by advertisement or otherwise that a manifestly incurable condition of sickness, disease, deformity, ailment or injury of any person can be cured.

"Advertising to cure or attempt to cure, or treat any person or persons for syphilis, for prostatic conditions or prostatic ailments.

"The making or signing by the holder of a certificate issued under the provisions of this or any prior medical practice act of any false certificate in his professional capacity and/or while acting within the scope of practice permitted by the certificate issued to him.

"Accepting employment from persons, firms or corporations who directly or indirectly solicit same."

*Senate Bill 155*, by Williams (referred to Committee on Public Health and Quarantine). Relating to courses of study required of applicants for certification under the State Medical Practice Act. Also requiring that senior, fourth or final year be completed in an approved medical school in the United States, or in lieu thereof has served at least one year in residence in a hospital approved by the board for internship located in the United States.

*Senate Bill 225*, by Young (referred to Committee on Prisons and Reformatories)—Skeleton bill. Providing for institution or farm for drug addicts.

*Senate Bill 229*, by Young (referred to Committee on Revision of Criminal Law and Procedure). Amending State Narcotic Act. Strikes out word "habitual" and makes it unlawful to administer, furnish or prescribe for "a user."

*Senate Bill 263*, by Young (referred to Committee on Public Health and Quarantine)—Skeleton bill. Amending Polson Act, relating to narcotics.

*Senate Bill 264*, by Young (referred to Committee on Public Health and Quarantine)—Skeleton bill. Similar to No. 263.

\* This list received from Mr. Ben Read, executive secretary of the Public Health League of California.

*Senate Bill 305*, by Difani (referred to Committee on Finance). An act to provide for the reimbursement of hospitals for expenditures incurred in the emergency care and treatment of indigent persons injured in motor vehicle accidents. Skeleton bill.

*Senate Bill 311*, by McColl (referred to Committee on Public Health and Quarantine)—Companion bill to No. 309.

*Senate Bill 390*, by Tickle (referred to Committee on Public Health and Quarantine)—Skeleton bill. An act to provide for the establishment and administration of a system of health insurance.

*Senate Bill 391*, by Tickle (referred to Committee on Public Health and Quarantine)—Companion bill to No. 391. An act to provide for the establishment, regulation and supervision of systems of health service insurance in California.

*Senate Bill 392*, by Parkman (referred to Committee on Public Health and Quarantine). Relating to the conduct of clinical laboratories and the licensing of clinical laboratory technologists for the purpose of protecting the public health and defining a clinical laboratory and a clinical laboratory technologist, and providing penalties for violation.

*Senate Bill 417*, by McCormack (referred to Committee on Governmental Efficiency). Authorizing a nursing survey to be made by the University of California.

*Senate Bill 454*, by Williams, Tickle and Difani (referred to Committee on Public Health and Quarantine)—Skeleton bill. To provide for establishment and administration of a system of health insurance for persons in certain income groups.

*Senate Bill 468*, by Williams (referred to Committee on Public Health and Quarantine). Relates to violations of Medical Practice Act. Provides for injunctions.

*Senate Bill 471*, by Difani (referred to Committee on Insurance). Relating to Medical and Hospital Service Insurers.

*Senate Bill 472*, by Difani (referred to Committee on Insurance). Relating to proceedings against insolvent insurers.

*Senate Bill 473*, by Difani (referred to Committee on Insurance). Adds a new section to the Insurance Code relating to Medical and Hospital Insurance.

*Senate Bill 474*, by Difani (referred to Committee on Insurance). Adds a new chapter to the Insurance Code relating to Medical and Hospital Service Insurers.

*Senate Bill 491*, by Snyder (also 492, 493, 494) (referred to Committee on Insurance). All relating to Compensation Insurance.

*Senate Bill 499*, by McGovern (referred to Committee on Public Health and Quarantine). Relating to penalties for violation of Dental Act Injunction Bill.

*Senate Bill 512*, by Swing (referred to Committee on Public Health and Quarantine). Amends Pharmacy Act.

*Senate Bill 534*, by Perry (referred to Committee on Hospitals and Asylums). An act relating to persons in private psychopathic institutions.

*Senate Bills 627 and 628*, both by Perry (referred to Committee on Judiciary). Relating to insane or incompetent persons.

*Senate Bill 662*, by Jespersen (referred to Committee on Revision of Criminal Laws and Procedure). Relating to cruelty to animals.

*Senate Bill 709*, by Difani (referred to Committee on Governmental Efficiency). An act creating a State Board of Eugenics.

*Senate Bill 760*, by Young (referred to Committee on Criminal Laws and Procedure). Amends Narcotic Act relating to Institutions for Drug Addicts.

*Senate Bill 824*, by Edwards (referred to Committee on County Government). Relating to powers of Boards of Supervisors.

*Senate Bill 831*, by Picrovich (referred to Committee on Judiciary). Amends Compensation Act.

*Senate Bill 831*, by Seawell (referred to Committee on Insurance). Amends Compensation Act.

*Senate Bill 862*, by Difani (referred to Committee on Military Affairs). Relating to exemption of soldiers and sailors from license fees for itinerant vendors of drugs—nostrum ointments or appliances sold for the cure of disease, injuries or deformities.

*Senate Bill 895*, by Difani (referred to Committee on Insurance). Relates to life and disability insurance.

*Senate Bill 905*, by Difani (referred to Committee on Insurance). Relates to miscellaneous casualty insurance.

*Senate Bill 995*, by Fletcher (referred to Committee on Revenue and Taxation). An act to amend Retail Sales Tax Act relating to exemption of hospitals from payment of tax.

*Senate Bill 1035*, by Jespersen by request (referred to Committee on Public Health and Quarantine). Amends Dental Practice Act relative to examining and licensing of persons who have been engaged as apprentices.

*Senate Bill 1056*, by Bigger (referred to Committee on Governmental Efficiency). Relating to registration of births.

#### II

#### ASSEMBLY BILLS

*Assembly Bill 58*, by Gilmore (referred to Committee on Public Health and Quarantine). Relating to meat inspection.

*Assembly Bill 59*, by Jones (referred to Committee on Public Health and Quarantine). Providing for formation and operation of garbage disposal districts.

*Assembly Bill 67*, by Geyer (referred to Committee on Public Health and Quarantine). Referring to sale of "cold storage eggs."

**Assembly Bill 99**, by Peyser (referred to Committee on Judiciary). Requires persons bringing actions for damages for personal injuries to submit to an examination of their persons by "a competent physician or physicians, surgeon or surgeons."

**Assembly Bill 101**, by Boyle (referred to Committee on Judiciary). Adds to property exempt from execution or attachment: "one motor vehicle not exceeding \$1,000 in value used by a physician, or surgeon, in the legitimate practice of his profession."

**Assembly Bill 172**, by H. J. Evans (referred to Committee on Public Health and Quarantine). Referring to "cold storage eggs."

**Assembly Bill 173**, by H. J. Evans (referred to Committee on Public Health and Quarantine). Referring to "cold storage eggs."

**Assembly Bill 188**, by Boyle (referred to Committee on Medical and Dental Laws). Relates to advertising food, drink, drug or cosmetic products by radio broadcasting and providing penalties for violation.

**Assembly Bill 195**, by Gilmore (referred to Committee on Public Health and Quarantine). Relating to meat inspection.

**Assembly Bill 235**, by Breed (referred to Committee on Social Service and Welfare). Permits county supervisors to secure care for indigent sick and dependent poor in "any hospital maintained and operated by any county or by the state or by any state college, university or other institution supported in whole or in part by taxation, or by any persons, firms or corporation in the county or city and county."

**Assembly Bill 236**, by Breed (referred to Committee on County Government).

**Assembly Bill 246**, by Cronin (referred to Committee on Medical and Dental Laws). An act for the regulation and control of corporations organized for the purpose of operating nonprofit hospital service plans.

**Assembly Bill 254**, by Cottrell (referred to Committee on Judiciary). Relating to reports of medical examinations and expert medical testimony in civil actions and proceedings.

**Assembly Bill 255**, by Cottrell (referred to Committee on Judiciary). Providing for selection of impartial expert medical witnesses and impartial medical examiners appointed by the court, from eligible lists or panels to be provided under the direction of the Civil Service Commission.

**Assembly Bill 270**, by Wright (referred to Committee on Governmental Efficiency and Economy). Establishes a Board of Institutions consisting of seven members appointed by the Governor. The Board to appoint the Director of Institutions and consult with him and furnish advice in regard to all questions of general policy as to the conduct of the department.

**Assembly Bill 287**, by Fulcher, Thorp and Eicke (referred to Committee on Social Service and Welfare). Permits county supervisors to secure care for indigents in hospitals "within or without the county or city and county."

**Assembly Bill 390**, by Crowley (referred to Committee on Judiciary). Relating to birth certificates in adoption cases.

**Assembly Bill 393**, by Fisher (referred to Committee on Judiciary). Permits commitment of insane persons or inebriates to private institutions.

**Assembly Bill 429**, by Donnelly (referred to Committee on Education). Requires schools to provide first medical aid equipment.

**Assembly Bill 493**, by Thorp (referred to Committee on Live Stock and Dairies). Relating to milk inspection.

**Assembly Bill 498**, by Thorp (referred to Committee on Live Stock and Dairies). Relating to milk inspection.

**Assembly Bill 504**, by Donhue (referred to Committee on Motor Vehicles). Requires Motor Vehicle Department to establish emergency first aid stations along the highways.

**Assembly Bill 542**, by Jones (referred to Committee on County Government). Permits cities and towns to contract with county health departments for services of such departments.

**Assembly Bill 543**, by Jones (referred to Committee on County Government)—Skeleton bill. Companion bill to No. 542.

**Assembly Bill 551**, by Fisher (referred to Committee on Judiciary). Relates to maternity hospitals or homes.

**Assembly Bill 564**, by Cronin, and **Assembly Bill 565**, by Cronin (referred to Committee on Public Health and Quarantine)—Skeleton bill. Amending Narcotic Act.

**Assembly Bill 603**, by Richle, Reaves, Rosenthal, Stream, Wallace, Pelletier, McCarthy, Flint, Lore, Miller and Morgan (referred to Committee on Social Service and Welfare). Provides that "in any county where a county hospital has been established, any expectant mother, regardless of the length of her residence in the county, who is unable to pay for her necessary care, must be admitted to such county hospital."

**Assembly Bill 616**, by Miss Miller (referred to Committee on Public Charities and Corrections)—Skeleton bill. Provides for institution or farm for drug addicts.

**Assembly Bill 674**, by Lyon (referred to Committee on Public Health and Quarantine). Establishing "Registered Sanitarians" under authority of Board of Public Health.

**Assembly Bill 690**, by Gilmore (referred to Committee on Insurance). An act to define life, and accident and health insurance on the assessment plan and to provide for the formation of corporations to conduct such insurance.

**Assembly Bill 701**, by Redwine (referred to Committee on Judiciary)—Skeleton bill. Relating to expense of

maintenance in state hospitals of persons charged with crime.

**Assembly Bill 760**, by Peyser by request (referred to Committee on Public Health and Quarantine). An act to provide for local health districts in any part of the state and defining their powers and duties.

**Assembly Bill 784**, by Boyle (referred to Committee on Public Health and Quarantine). An act relating to the sale, disposition of, advertising, and control through licensing, of prophylactics and contraceptives.

**Assembly Bill 785**, by Boyle (referred to Committee on Medical and Dental Laws). Relating to hours of employees selling drugs and medicine.

**Assembly Bill 786**, by Lore (referred to Committee on County Government). Relates to powers of Boards of Supervisors.

**Assembly Bill 791**, by Pelletier (referred to Committee on Insurance). An act to provide for the establishing of unemployment and social insurance.

**Assembly Bill 819**, by Lyon (referred to Committee on Judiciary). Amends law referring to commitment of insane persons.

**Assembly Bill 867**, by Patterson (referred to Committee on Insurance)—Skeleton bill. An act relating to health insurance.

**Assembly Bill 890**, by Fisher (referred to Committee on Medical and Dental Laws). Amends Medical Practice Act relating to Chiropractors.

**Assembly Bill 912**, by Miller (referred to Committee on Public Health and Quarantine). Amends Cosmetology Act.

**Assembly Bill 946**, by Reaves (referred to Committee on Public Health and Quarantine). Chiropractic Act.

**Assembly Bill 954**, by Kallam (referred to Committee on Hospitals and Asylums). County Hospital Act defining indigent sick, etc.

**Assembly Bill 970**, by Corwin (referred to Committee on Conservation). Improvements at Pacific Colony and State Narcotic Hospital.

**Assembly Bill 990**, by Cronin (referred to Committee on Medical and Dental Laws). Amending Dental Act relating to advertising.

**Assembly Bill 992**, by Cronin (referred to Committee on Medical and Dental Laws). Amends Dental Act relative to diagnosis.

**Assembly Bill 998**, by Boyle (referred to Committee on Education). Relating to average daily attendance in schools in connection with pupils excused to visit dentists.

**Assembly Bill 1009**, by Nielsen (referred to Committee on Medical and Dental Laws). Amends Clinic Act to fix fee at \$20.

**Assembly Bill 1010**, by Gilmore (referred to Committee on Public Health and Quarantine). Cannery inspection.

**Assembly Bill 1022**, by Cunningham (referred to Committee on Medical and Dental Laws)—Skeleton bill. Dental Act.

**Assembly Bill 1023**, by McMurray (referred to Committee on Medical and Dental Laws)—Skeleton bill. Dental Act.

**Assembly Bill 1037**, by Peyser (referred to Committee on Medical and Dental Laws). Regulating use of x-rays on living persons.

**Assembly Bill 1046**, by Richle (referred to Committee on Medical and Dental Laws). An act to authorize and permit physicians, surgeons, medical doctors, osteopaths, chiropractors and any other practitioners who have been duly licensed to practice similar professions under the laws of California, to enter into any contracts or agreements with their patients for professional services or hospitalization without complying with the provisions of law applicable to insurance and insurance contracts.

**Assembly Bill 1076**, by Hunt (referred to Committee on Medical and Dental Laws)—Skeleton bill. Dental Act.

**Assembly Bills 1096 and 1097**, by Anderson (referred to Committee on Social Service and Welfare). To provide for establishment and administration of systems of health insurance.

**Assembly Bill 1139**, by Cunningham (referred to Committee on County Government). Relating to emergency aid for sick and injured.

**Assembly Bill 1140**, by Cunningham (referred to Committee on Judiciary). Relating to apprehension of insane persons and the issuance of warrants therefor and relating to the duties of court commissioners.

**Assembly Bill 1202**, by Cottrell (referred to Committee on Judiciary). Relating to duty of hospitals, pharmacies, physicians and other persons to report cases of persons suffering from wounds and injuries.

**Assembly Bills 1212-1213-1214-1215**, by Lyon (referred to Committee on Medical and Dental Laws). Amending Optometry Act.

**Assembly Bill 1222**, by Lyon (referred to Committee on Public Health and Quarantine). Regulating traffic in cosmetics.

**Assembly Bill 1254**, by Lyon (referred to County Government). Authorizing counties to recover cost of care of harmless insane.

**Assembly Bill 1255**, by Lyon (referred to Committee on County Government). Amending Psychopathic Parole Act, to authorize counties to recover cost of care of persons mentally disordered.

**Assembly Bill 1263**, by Lyon (referred to Committee on County Government). Authorizing Boards of Supervisors to provide for the creation and operation of a system of insurance and pension for the benefit of physicians and nurses employed in county institutions, to procure group insurance for the benefit of such employees and to provide for the payment of premiums therefor.

**Assembly Bill 1272**, by Lyon (referred to Committee on Public Health and Quarantine). Amending Cosmetology Act.

*Assembly Bill 1299*, by Cunningham (referred to Committee on County Government). Relating to county charges.

*Assembly Bills 1302 and 1303*, by Boyle (referred to Committee on Medical and Dental Laws). Amending Pharmacy Act.

*Assembly Bill 1308*, by Field (referred to Committee on Public Health and Quarantine). Amending Cosmetology Act.

*Assembly Bill 1347*, by Boyle (referred to Committee on Public Health and Quarantine)—Skeleton bill. Members of Board of Health.

*Assembly Bills 1353 and 1354*, by Desmond (referred to Committee on Public Health and Quarantine)—Skeleton bills. Board of Health.

*Assembly Bill 1355*, by Patterson (referred to Committee on Medical and Dental Laws)—Skeleton bill. Medical Practice Act.

*Assembly Bill 1361*, by Hunt (referred to Committee on County Government)—Skeleton bill. County hospitals.

*Assembly Bill 1367*, by Riley (referred to Committee on Public Health and Quarantine). County Sanitation Districts.

*Assembly Bill 1449*, by Maloney by request (referred to Committee on Judiciary). Relating to alienists in criminal cases.

*Assembly Bill 1544*, by Maloney by request (referred to Committee on Governmental Efficiency and Economy). Relating to state psychiatrists and the establishment of a division of psychiatry in the Department of Institutions.

*Assembly Bill 1545*, by Maloney by request (referred to Committee on Crime Problems). Examination of persons charged with crime.

*Assembly Bill 1552*, by Anderson and Boyle (referred to Committee on Governmental Efficiency and Economy). An act to establish a State Board of Qualifying Certificate Examiners in the fundamental sciences underlying the practices of the healing arts, to provide for its organization and powers, to provide that certification by such a board be a prerequisite to eligibility for examination for a license to practice the healing arts and to define healing arts—basic science.

*Assembly Bill 1607*, by Johnson, Fisher, Breed, Corwin, Cunningham, Martin, Wallace (referred to Committee on Governmental Efficiency and Economy). Creating State Board of Eugenics.

*Assembly Bill 1615*, by Redwine and Martin (referred to Committee on Public Health and Quarantine). An act to restrain aliens who are or may become invalids or infected with diseases from entering the state.

*Assembly Bill 1672*, by Cottrell (referred to Committee on Hospitals and Asylums). Appropriation for construction Department of Institutions.

*Assembly Bills 1673 and 1674*, by Cottrell and Anderson (referred to Committee on Hospitals and Asylums). Appropriations for Agnews.

*Assembly Bill 1690*, by H. J. Evans (referred to Committee on Insurance). Amending workmen's compensation relating to medical treatment.

*Assembly Bill 1765*, by Cronin (referred to Committee on Medical and Dental Laws). An act to establish standards for the granting and use of professional degrees in the learned professions and providing penalties for the violation thereof.

*Assembly Bill 1788*, by Crowley (referred to Committee on Hospitals and Asylums). Appropriations for Napa.

*Assembly Bill 1839*, by O'Donnell (referred to Committee on Medical and Dental Laws). An act to provide for the adoption of a uniform narcotic drug act.

*Assembly Bill 1840*, by O'Donnell (referred to Committee on Medical and Dental Laws). An act regulating traffic in narcotics.

*Assembly Bill 1866*, by Reeves (referred to Committee on Insurance). Amending Compensation Act.

*Assembly Bill 1872*, by Boyle (referred to Committee on Judiciary)—Skeleton bill. Bonds for costs in civil action for malpractice.

*Assembly Bill 1909*, by Patterson (referred to Committee on Insurance). Health Insurance Act.

*Assembly Bill 1918*, by Clark (referred to Committee on Insurance). Adding section to Compensation Act relating to hospital records of persons receiving compensation thereunder.

*Assembly Bill 1919*, by Clark (referred to Committee on Insurance). Amending Compensation Act relating to presumptions in respect to injuries to employees.

*Assembly Bill 1925*, by Reaves (referred to Committee on Medical and Dental Laws). Relating to disposition of human bodies.

*Assembly Bill 1927*, by Flint (referred to Committee on Hospitals and Asylums). Relating to tuberculosis subsidies.

*Assembly Bill 1928*, by Flint (referred to Committee on Hospitals and Asylums). Relating to tuberculosis bureaus.

*Assembly Bill 1929*, by Flint (referred to Committee on County Government). Skeleton bill.

*Assembly Bill 1943*, by Scudder (referred to Committee on Medical and Dental Laws). Providing for regulation of laboratories.

*Assembly Bill 1946*, by Miller (referred to Committee on Medical and Dental Laws). Relating to traffic in narcotics.

*Assembly Bill 1947*, by Miller (referred to Committee on Medical and Dental Laws). Amending Nursing Act.

*Assembly Bill 2154*, by Riley (referred to Committee on Public Health and Quarantine). Establishment of a bureau in Board of Public Health for suppression of noxious odors.

*Assembly Bill 2158*, by Clark (referred to Committee on Judiciary). An Act making it unlawful for hospitals, clinics, sanitariums, physicians, surgeons, or any other persons to refuse inspection of records by attorneys.

*Assembly Bill 2209*, by Clark (referred to Committee on Insurance). Amending Compensation Insurance Act relating to testimony by physicians.

*Assembly Bill 2216*, by Richie (referred to Committee on Insurance). Amending Compensation Act.

*Assembly Bill 2286*, by Lore (referred to Committee on County Government). Relating to the powers of boards of supervisors.

*Assembly Bill 2304*, by Flint (referred to Committee on Hospitals and Asylums). An Act to provide for the regulation of the organization and operation of hospital associations.

*Assembly Bill 2305*, by Hornblower (referred to Committee on Medical and Dental Laws). Amending Medical Practice Act relating to chiropody.

*Assembly Bill 2371*, by O'Donnell (referred to Committee on Medical and Dental Laws). An act to provide for the adoption of a uniform narcotic drug act.

*Assembly Constitutional Amendment 46*, by Reaves (referred to Committee on Constitutional Amendments). Relating to practice of chiropractic.

#### ANOTHER SUMMARY OF SOME PROPOSED CALIFORNIA LEGISLATION

From *The Journal of the American Medical Association*, February 16, 1935, page 568, the following is quoted because of the additional information contained therein concerning some of the proposed California laws:

S. 98 proposes to make it unlawful, except for licensed physicians and for persons licensed specifically by the State Board of Health so to do, to perform diagnostic tests on cultures or material from persons suffering from infectious or contagious diseases. S. 309 proposes that any person convicted of distributing unlawfully narcotic drugs, who is himself not a narcotic addict, may be punished, in addition to the other penalties provided by the Act, by from one to twenty lashes at a whipping-post. S. 391 proposes to establish a system of compulsory and voluntary health insurance. The bill was introduced only by title, however, and the remainder of the bill is to be inserted by the Committee on Public Health and Quarantine, to which this bill has been referred. S. 392 proposes to make it unlawful to conduct a clinical laboratory unless it be under the immediate direction of a licensed clinical laboratory technologist licensed by the State Board of Health. The State Board of Health is to license as a clinical laboratory technologist any licensed practitioner of the healing art who has specialized in general clinical laboratory work, such as bacteriology, serology, biochemistry and parasitology, and other allied subjects for at least three years. It is also to license (1) any other person who for more than eight years has been engaged continuously and actively in the work and direction of a clinical laboratory and (2) any other person who can qualify by written and practical examinations to be given by the board. The provisions of the bill, however, are not to apply to any licensed physician maintaining a laboratory in his own office for use in his own practice. S. 413 prohibits the employment of pharmacists and pharmacy clerks for more than an average of six hours a day, for more than seventy-two hours in any two consecutive weeks, or for more than twelve days in any two consecutive weeks. A. 416, to amend the Workmen's Compensation Act, proposes to permit chiropractors to render the "medical" care to injured workmen for which the Act makes the employer liable. A. 551, to amend the laws regulating the operation of maternity hospitals, proposes to make it unlawful for any such hospital to offer, as an inducement to a woman to enter therein, to dispose of her child or children for adoption. A. 603, to amend the law relating to county hospitals, proposes to require the admittance of any expectant mother, unable to pay for the necessary care, to any county hospital, regardless of her length of residence in the county. A. 761, to amend the Retail Sales Tax Act of 1933, proposes to exempt from its provisions the gross receipts from the sale of medicine and medical supplies. A. 890, to amend the provisions of the Medical Practice Act with respect to chiropody, proposes (1) to make the words "chiropody" and "podiatry" synonymous and (2) to define "mechanical treatment," which chiropodists are authorized to employ, as the employment of appliances to the plantar or lateral surfaces of the foot or feet, or of pads, or the use of adhesive tape strappings, or any forcible means for the correction or treatment of any deformity of the foot or feet but does not permit the treatment of fractures of the bones of the foot or feet or the application of splints or casts; provided, however, that the manufacture, the recommendation or the sale of corrective shoes or appliances for the human feet shall not be considered as mechanical treatment. A. 1037 proposes to make it unlawful for any person to own, possess or operate any x-ray device or x-ray laboratory unless such device or such laboratory is operated under the direct supervision of a person licensed by the State Board of Health. Apparently only licentiates of the Board of Medical Examiners, licensed osteopaths and licensed dentists are to be eligible for licensure by the Board of Health. Such practitioners are to be permitted to possess and use such devices "as are incident to the treatment of patients by means other than x-ray or x-ray devices."

## TWENTY-FIVE YEARS AGO\*

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 3, March 1910

#### From Some Editorial Notes:

**Annual Meeting.**—The Committee on Arrangements announces that the meetings of the State Society at Sacramento, April 19, 20, and 21, 1910, will be held in the Elks Building, which is located conveniently near the Hotel Sacramento. . . . Get out of the rut; go to the annual meeting; meet several hundred of your fellow physicians; learn something new; teach something that you have found out and that others ought to know. Go to the meeting, even if at some sacrifice. . . .

**Ring Talk.**—In the State Society, in many, if not all county societies, in every sort and form of organization of men, you will hear the same sort of talk: that things are run by a "ring," and "clique," a "machine." And it is perfectly true; all organizations of men are always managed and conducted—or "run"—by a few men who will give their time and their energy to the necessary work; probably very few of those who do the work would not be glad to be quit of it, if someone else would step forward and relieve them. . . .

**Plague News.**—The many friends of Dr. Rupert Blue will be glad to know that he has been made a Fellow of the Royal Society of Tropical Medicine of London in recognition of his remarkable work in fighting plague in San Francisco. . . .

**Public Health Commission.**—The Public Health Commission of the State Society is, as all of our members know, one of the most active bodies or committees connected with the Society. Since its very inception this Commission has done a good deal of the very best, high-grade work. . . .

**Open Meetings.**—At the last session of the American Medical Association a resolution was introduced and passed, requesting all county medical societies to hold at least one open or public meeting each year. Such meetings will be of the very greatest benefit; the people generally do not know what medical societies are trying to do; they do not understand our present-day efforts toward the betterment of public health matters; they are at sea as to the real reason for proper medical laws and for the compulsory vaccination of children. . . .

**"What Fools These Mortals Be."**—In *Life*, a weekly publication more noted for its smartness than its wit, and which is supposed to throw the searchlight upon the follies, foibles, sins, whims and caprices of human-kind, there recently appeared a two-page illustration entitled "The Reward of Virtue." . . . This is *Life's* idea of humor; its tribute to the medical profession—for it wishes to imply that the blood-thirsty individual is a physician. . . . This horrible illustration, so unwholesome that it should have been suppressed by the authorities, is not without purpose. It is this silly journal's contribution to the fight which is being made against the Rockefeller Institute of Medical Research by certain fanatics in New York. . . . That the mortality in cerebrospinal meningitis has been reduced from 75 to 25 per cent is mere drivel to these misguided sentimentalists. People who do not choose to fight fair are not open to argument. . . .

\* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, page 17)

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA\*

By CHARLES B. PINKHAM, M. D.  
Secretary-Treasurer

### Official Notices

**Board Proceedings.**—At a regular meeting of the Board of Medical Examiners held in Los Angeles February 4 to 7, inclusive, seventy-two applicants wrote the examination.

Twelve licentiates were called before the Board on charges of violations of Section 14 of the Medical Practice Act. The following changes in the status of licentiates were made:

Stanley Boller, M. D., found guilty of narcotic derelictions, was, on February 6, 1935, placed on five years' probation, without narcotic privileges.

Brandon A. Bowlin, M. D., found guilty of narcotic derelictions, was, on February 6, 1935, placed on probation for a period of three years, without narcotic privileges.

Ethel L. Leonard, M. D., found guilty of narcotic derelictions, was, on February 6, 1935, placed on probation, without narcotic privileges.

Edward P. Genochio, M. D., found guilty on February 6, 1935, under Subdivision 8 of Section 14, re advertising, was placed on probation for three years.

Hovsep H. Mahdesian, M. D., found guilty of narcotic derelictions, was, on February 7, 1935, placed on probation for a period of two years, without narcotic privileges.

Louise Patterson, M. D., found guilty on a charge of use of fictitious name, was, on February 7, 1935, suspended from practice for a period of two years.

William T. Schwabland, M. D., charged with use of fictitious name, was, on February 6, 1935, suspended from practice for a period of one year.

The charges against George H. French, M. D., deceased; LeRoy B. Humphrey, M. D., and Henry F. Kamman, M. D., were dismissed.

The case of Byron H. Pelton, M. D., charged with narcotic dereliction, was partially heard, and continued to the San Francisco meeting, which opens July 8.

### News Items

"A bill to provide for the licensing of all persons who perform laboratory tests on materials taken from persons suffering from infectious or contagious diseases, was introduced in the Senate by Senator Herbert W. Slater of Sonoma County. The bill is in line with another by Slater, providing for the control by the State of dispensing of serums and requiring that dispensers be licensed. Both measures are the outgrowth of the death of a two-year-old boy in Healdsburg last year after receiving an injection of infantile paralysis serum." (Sacramento *Bee*, January 18, 1935.)

"Chiropractic doctors, operating under the State Act prescribed for them, won two decisions in the District Court of Appeal yesterday. The high court, however, declined to pass upon the scope of Section 7 of the Act to differentiate between chiropractic and the medical profession practice. An action brought through *quo warranto* proceedings by the State and the Chiropractic League of California against Dr. Roscoe C. Steele and his wife, Lois, Palo Alto, in which they were enjoined from practicing by Superior Judge James of Santa Clara County, was reversed. At the same time the high court held that a contract between Dr. M. James McGranaghan for service did not include in its scope attention that might be construed to be under other medical jurisdiction." (San Francisco *Chronicle*, January 29, 1935.)

\* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section, page 18)